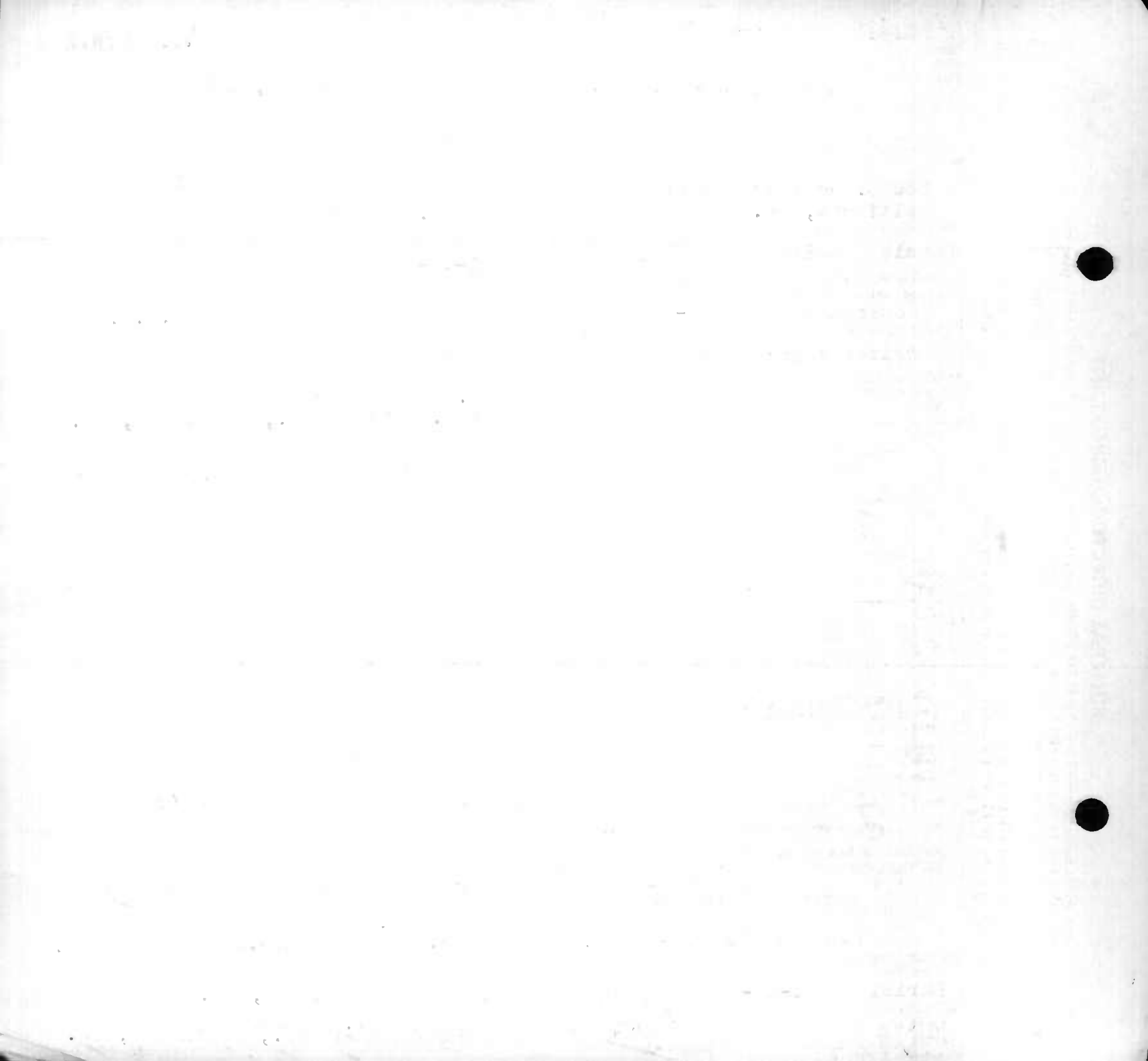


FUNERAL DIRECTOR: IMPORTANT

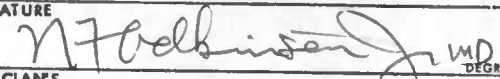
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-652 71 0501 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0501 | |
|---|---------|--|-----------------------------------|---|--|--|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Josephine Fronckowiak | | January 13, 1971 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 336 S. Bouldin Street Baltimore, Md. | | | | Maryland Baltimore 2610 | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 336 S. Bouldin Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-13-89 | | 82 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| Housewife | | | - | | Poland | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Walter Zienkowska | | | Agnes | | U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | - | | Mrs. Julia Bothoff 336 S. Bouldin St., Baltimore, Md. | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | Anterior wall C.V. MI 10/15/71 | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 11 1958 to Jan. 13 1971 that (I) (we) last saw the deceased alive on July 11 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Benjamin Highstein, M.D. | | | | 1/15/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Benjamin Highstein, M.D. | | | | 121 S. Highland Ave., Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 1-16-71 | | Holy Rosary Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 19 1971 | | Robert E. Kelley, M.D. | | Nicholas T. Matthews | | 3021 Eastern Ave., Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 13-240 | | | | 71 0502 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0502 | | | |
|--|--|-------------------------|--|---|--|------------------------------------|--|---|--|----------------------------|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Catherine M. Buckel | | | | | | | | 2. DATE AND HOUR OF DEATH 1/14/71 11:55 PM | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland | | | | B. COUNTY 2719 | | | |
| C. CITY OR TOWN Baltimore | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | E. STREET AND NUMBER 5611 Jonquil Ave., Balto. Md. 21215 | | | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-24-06 | | 9. AGE (In years last birthday) 64 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | | | 11. BIRTHPLACE (State or foreign country) Pennsylvania, Milroy | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME George Missel Sr. | | | | | | | | 14. MOTHER'S MAIDEN NAME Catherine Kuckenmeister | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 214-40-5149 | | | | 17. INFORMANT Henry J. Buckel, 5611 Jonquil Ave., 21215 BCH, 4940 Eastern Avenue, Baltimore 21224 | | | | | | | |
| 18. 20011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | CAUSE OF DEATH ASPIRATION PNEUMONITIS BRONCHOPNEUMONITIS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8hrs | | | |
| | | | | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RECURRENT BILATERAL PLEURAL EFFUSIONS | | | | 3 mo. | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: WIDESPREAD LYMPHOSARCOMA | | | | 2 yrs | | | | | | | |
| | | | | (C) | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 1/13/71 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (A) (this hospital) attended the deceased from 11/25/70 19 to 1/13/71 19 that (I) (W) last saw the deceased alive on 1/13/71 19 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (W) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE  | | | | | | | | 23B. DATE SIGNED 1/14/71 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) N. Franklin Adkinson, Jr., MD | | | | | | | | 23D. ADDRESS C/O Baltimore City Hospitals Johns Hopkins Hospital, Baltimore, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 1/19/71 | | | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Pikesville, Baltimore, Maryland | | | |
| 25A. DATE RECD BY HEALTH DEPT. JAN 10 1971 | | | | 25B. NAME OF REGISTRAR 226132 | | | | 25C. FUNERAL DIRECTOR Loring Biers | | | | ADDRESS 18728 Liberty Rd. Randallstown, Md. | | | |

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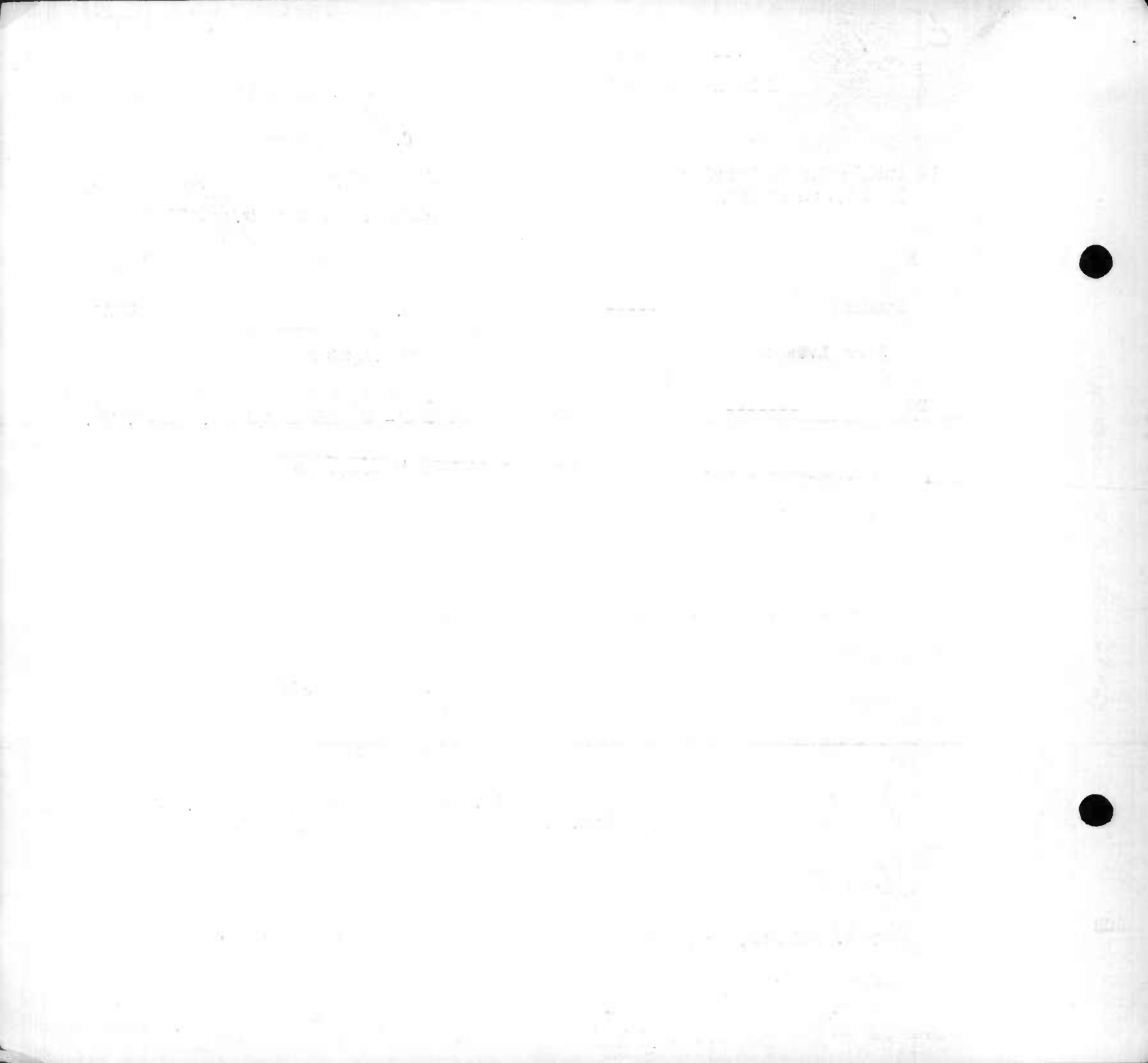
XX

FUNERAL DIRECTOR: IMPORTANT

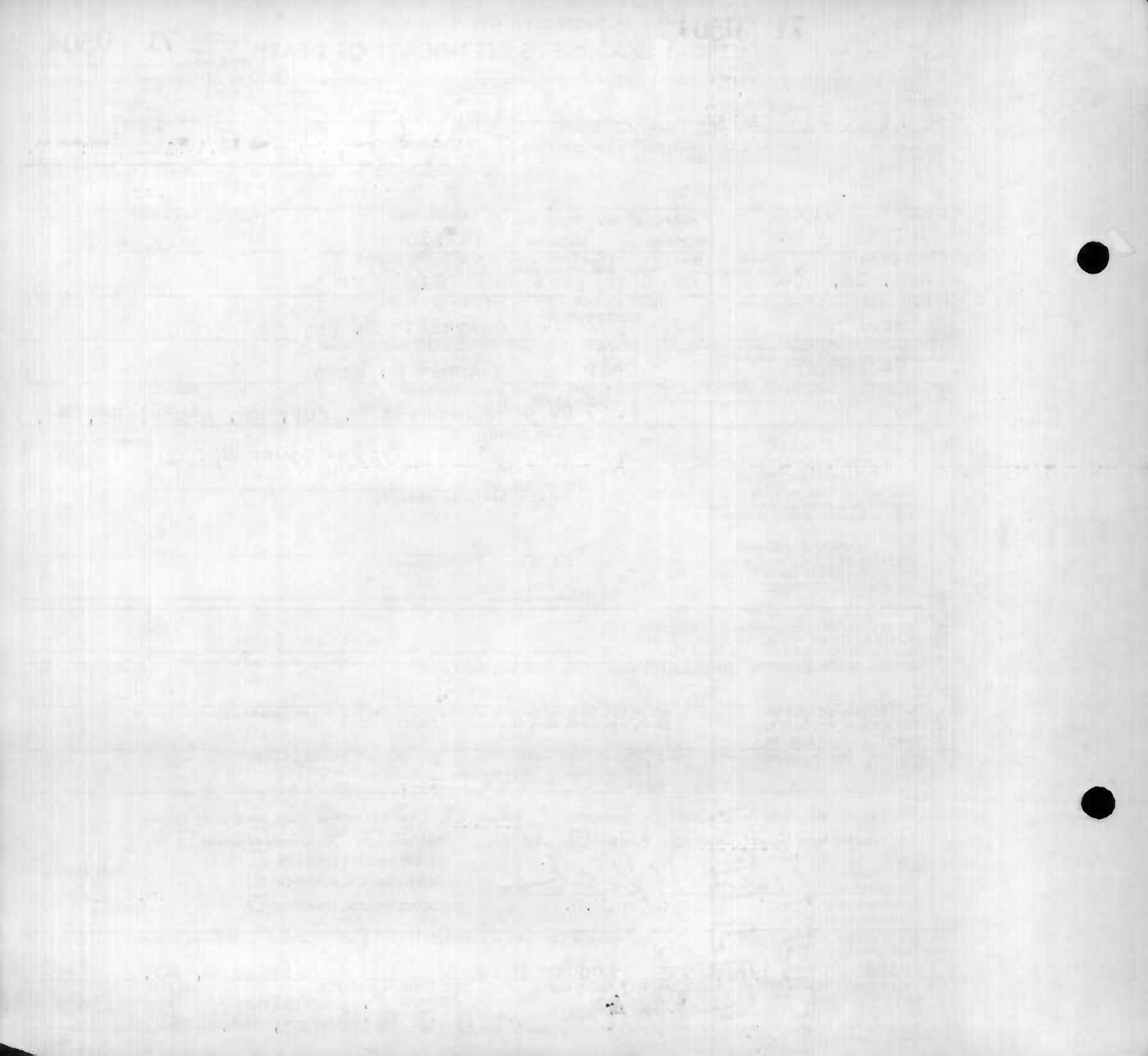
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0503 | | REG. NO. 71 0503 | |
|--|---------------------|---|--|--|---|---|------------------------|
| BIRTH NO. E-524 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BRET KEITH ENGEL | | | | 2. DATE AND HOUR OF DEATH Jan. 14, 1971 11 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Howard | | | |
| | | | | C. CITY OR TOWN Ellicott City | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3156 W. Springs Drive, 21043 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/18/62 | 9. AGE (in years last birthday) 8 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John L. Engel | | | | 14. MOTHER'S MAIDEN NAME Mildred Timanus | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. ? None | | 17. INFORMANT ADDRESS John L. Engel, 3156 West Springs Drive, 21043 Records- US PHS Hospital, Balto, Md. | | | |
| 18. CAUSE OF DEATH 202.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Burkitt's lymphoma (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 14 19 70 to Jan. 14 19 71 that (I) (we) last saw the deceased alive on Jan. 14 19 71 and that (in me) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Gary E. Feldman, M.D. | | | | 23B. DATE SIGNED 1/14/71 | | 23C. PHYSICIAN'S NAME (Type) Gary E. Feldman, Surg (R) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/18/71 | | 24C. NAME OF CEMETERY OR CREMATORY Bosley Cemetery | | 24D. LOCATION (City, town, or county) (State) Sparks, Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Loring Byers | | 25D. ADDRESS 2728 Liberty Rd. Randallstown 21133 | |



| | | | | | |
|---|------------------|---|---|--|---|
| J-000 71 0504 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0504 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) S. WENDELL JOY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year January 12, 1971 | | Hour 10:05 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Howard | | | | | |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Elkridge | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 9. DATE OF BIRTH Jan. 28, 1904 | | 10. AGE (In years lost birthday) 67 | E. STREET AND NUMBER 720 Elm Avenue | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | 13. FATHER'S NAME Everett M. Joy | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 14B. KIND OF BUSINESS OR INDUSTRY Self | 15. MOTHER'S MAIDEN NAME Annie M. Dean | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 219 07 4642 | 18. INFORMANT ADDRESS 2 Wendell S. Joy, Jr. Linthicum, Md. | | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/13/71 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/16/70 | 24C. NAME of CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR James F. Burnside | | 25C. FUNERAL DIRECTOR ADDRESS 955 Southridge Rd. Baltimore, Md. 21228 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/7/88

Page 100

Thompson's Lane 51

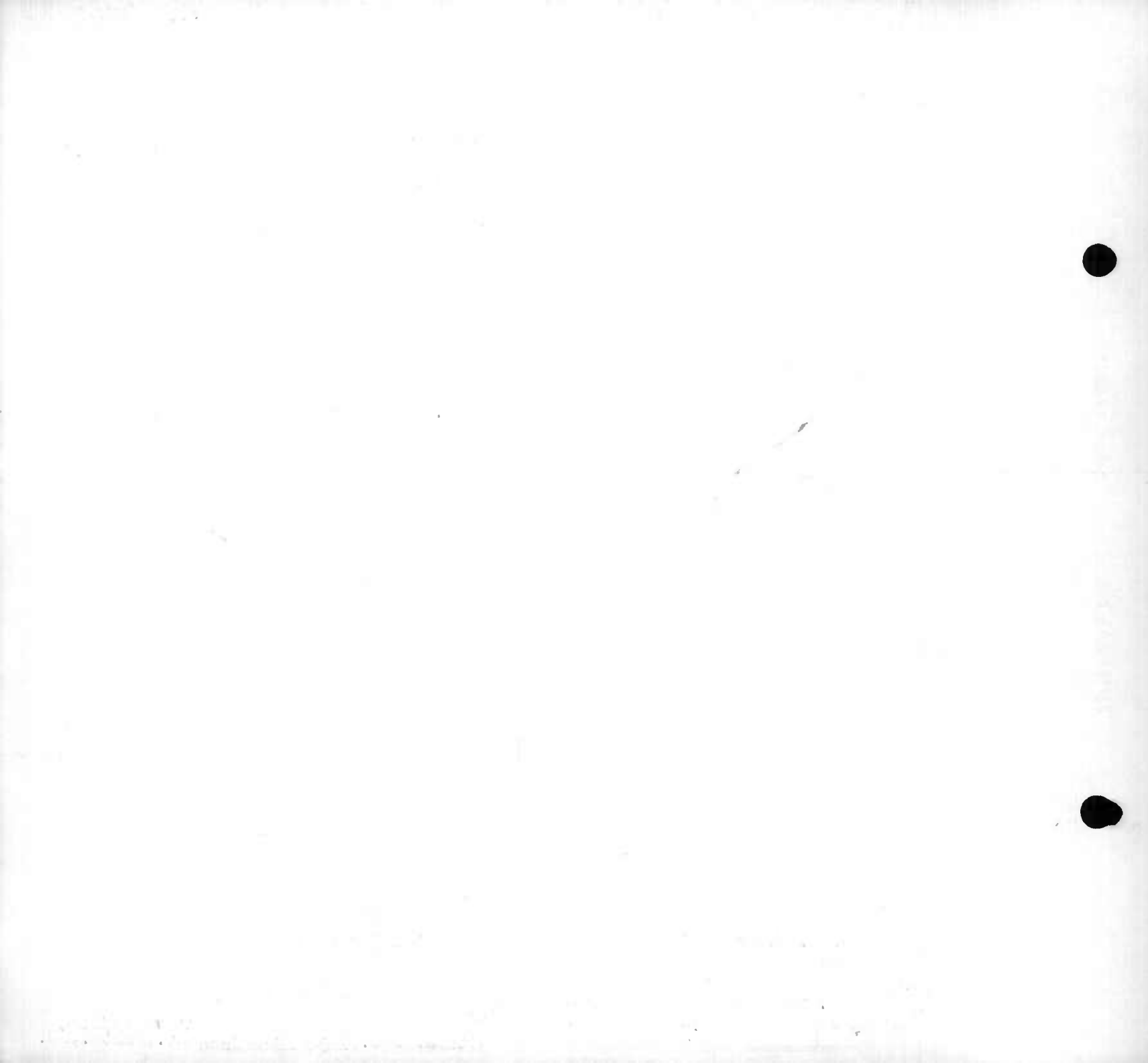
Thompson's Lane 51
Thompson's Lane 51
Thompson's Lane 51
Thompson's Lane 51
Thompson's Lane 51

(1) Sub-Station 100
Thompson's Lane 51

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------------------|--|---|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. <u>35-100</u> | | 1. NAME OF DECEASED (Type or Print) <u>Marjorie Shipp</u> | | 2. DATE AND HOUR OF DEATH <u>1/17/71</u> <u>9:45 A</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2834</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Hood Convalescent Home Inc.</u> <u>5313 Edmondson Ave</u> <u>Baltimore, Md 21229</u> | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>1112 Wedgewood Road (21229)</u> | | | | | |
| 5. SEX <u>F.</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-20-1913</u> | 9. AGE (In years last birthday) <u>57</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Charles Lauterbach</u> | | 14. MOTHER'S MAIDEN NAME <u>Della Fury</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>212-03-2864</u> | | 17. INFORMANT <u>Mrs. Lynn Bartosz</u> | |
| ADDRESS <u>1112 Wedgewood Road</u> | | 18. <u>412.31</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Rheumatoid Arthritis</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>?</u> <u>20 yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> 19 <u>71</u> to <u>January 17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Jan 16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>D. C. MacLaughlin</u> | | DEGREE <u>D. C. MacLaughlin</u> | | 23B. DATE SIGNED <u>1/17/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin</u> | | 23D. ADDRESS <u>303 North Rolling Road</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/20/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 24E. FUNERAL DIRECTOR <u>Witzke, INC., 1630 Edmondson</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. ADDRESS <u>(Cayonsville)</u> <u>Av., Balto., MD.</u> | |



| 71 0507 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0507 | |
|--|--|--|--|--|--|
| R-300 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | LILLIAN REID | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | University Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 15 1971 9:24 p.m. | |
| 6. SEX female | | 7. RACE white | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1902 | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH Feb. 23, 1899 | | 10. AGE (In years last birthday) 71 | | E. STREET AND NUMBER 1408 W. Lombard St. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William Crutchley | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Lillian Crosby | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 215-01-1249A | | 18. INFORMANT Mr. Robert E. Reid, 1408 W. Lombard St., Balto. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic cardiovascular disease | | (A) IMMEDIATE CAUSE Digitalis overdose DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1408 W. Lombard St. 19-02 | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1-15-71 9:03 p.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Ingested overdose | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Isidore Mihalakis</i> M.D. DATE SIGNED 1-17-71 EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-20-71 | | 24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 24E. NAME OF REGISTRAR JAN 19 1971 | | 24F. FUNERAL DIRECTOR ADDRESS Witke, 4101 Edmondson Av., Balto., Md. 21229 | |

Letter from M.E.'s office

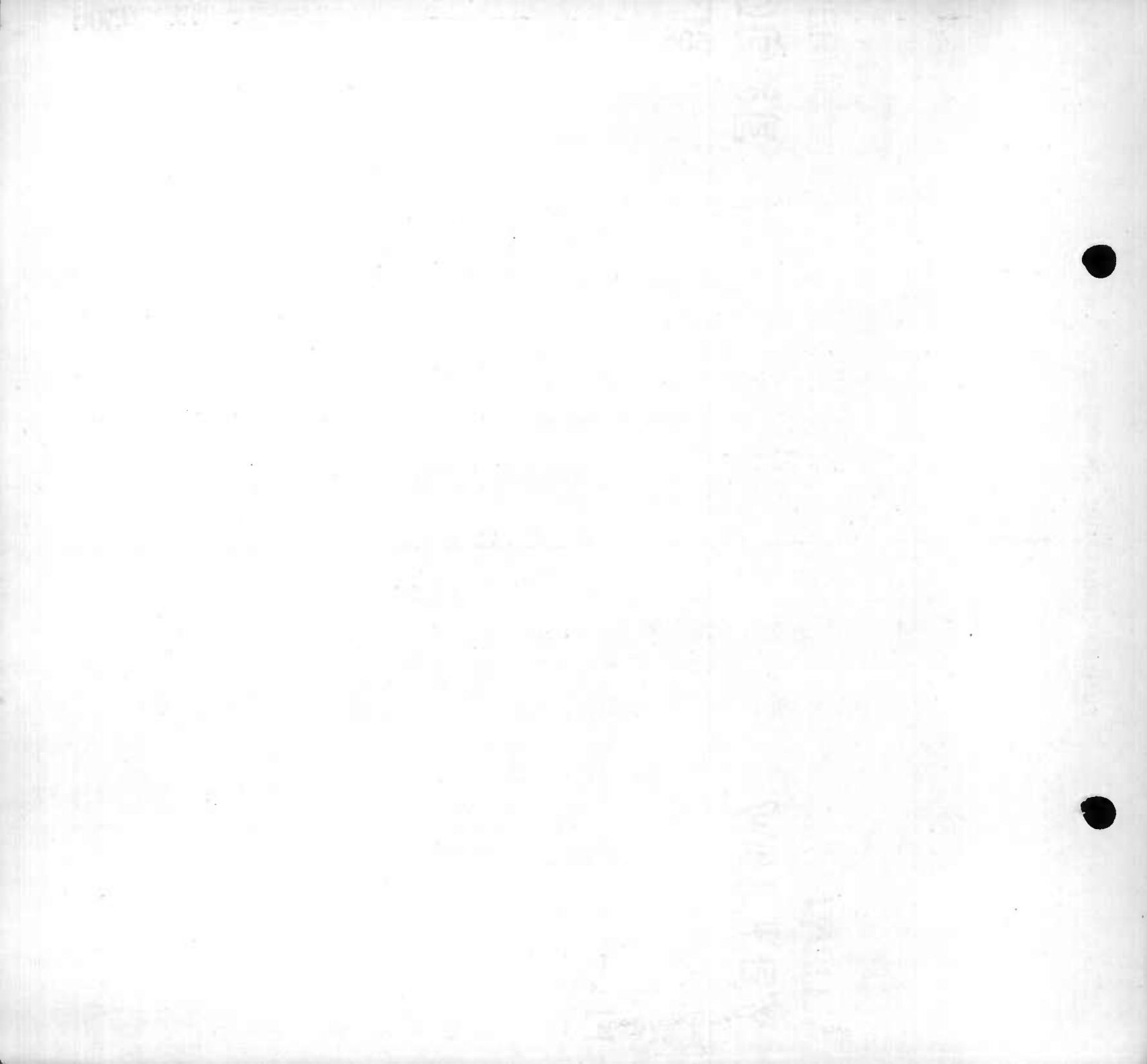
3-17-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

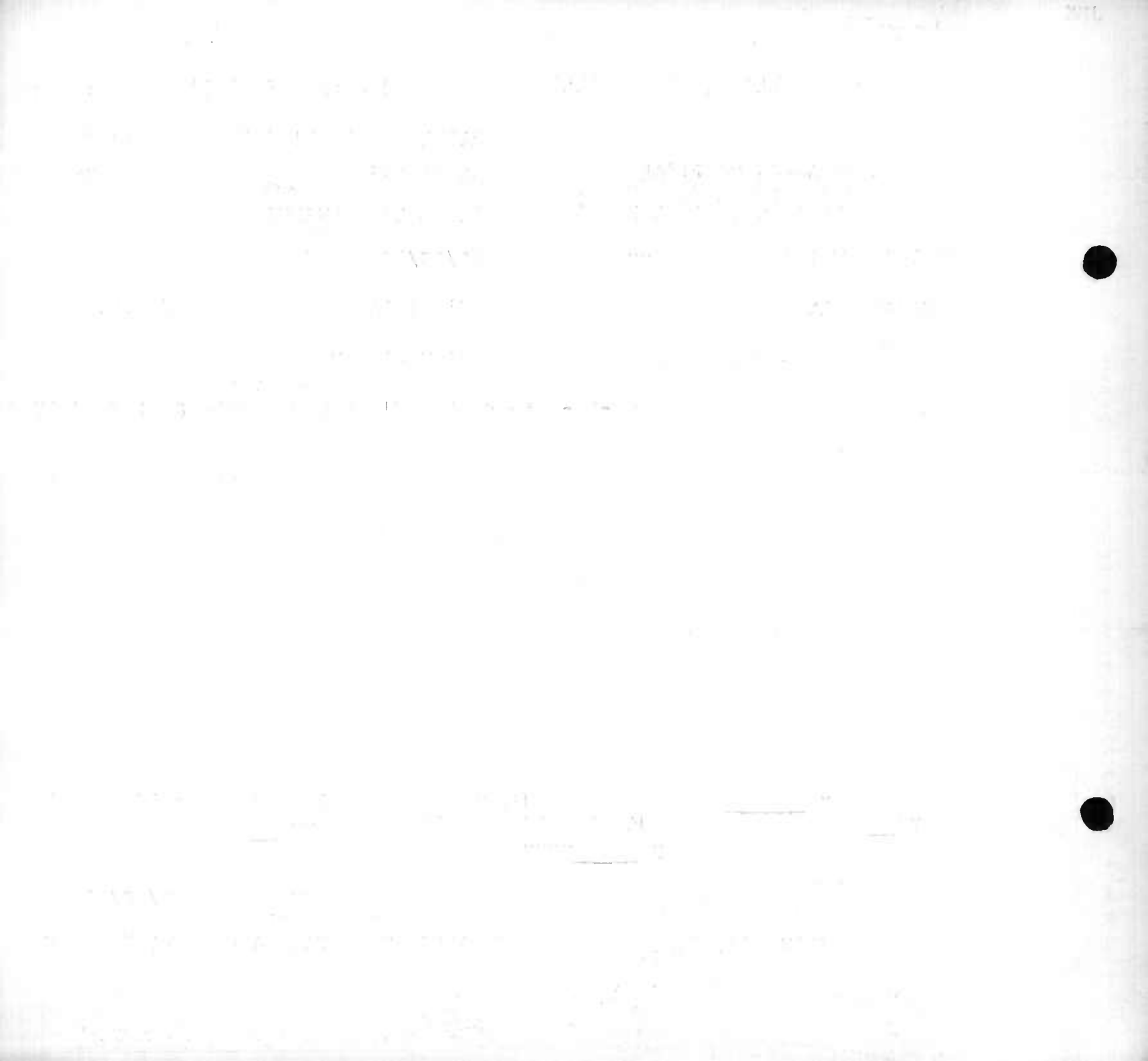
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
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| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0508 | |
| 1-520 71 0508 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) LEE E. LINK | | 2. DATE AND HOUR OF DEATH Jan 12, 1971 9:30 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTIMORE GENERAL HOSP. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2534 C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 825 FREEMAN ST. | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-2-18 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday) 52 |
| 11. BIRTHPLACE (State or foreign country) Albany, New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Hymen Link | | 14. MOTHER'S MAIDEN NAME Bertha Strauss | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mr. Victor Link |
| | | ADDRESS 5832 Doris Place Alexandria, Va. | |
| 18. 436.01 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident MINUTES (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerosis | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 26, 70 19 to Dec 23 19 70 , that (I) (we) last saw the deceased alive on 12-23-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Edmund Garney MD | | 23B. DATE SIGNED Jan 13-1971 | |
| 23C. PHYSICIAN'S NAME (Type) EDMUND GARNEY MD | | 23D. ADDRESS 3001 STH HANOVER ST Balto Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/15/71 | 24C. NAME OF CEMETERY or CREMATORY King David Memorial Garden | 24D. LOCATION (City, town, or county) (State) Falls Church, Virginia |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR 000 | 25C. FUNERAL DIRECTOR Donald M. Stein Hebrew Mem. Fun. Home, Inc. St. NW, WashDC | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. B-452 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0509 | |
| 1. NAME OF DECEASED (Type or Print) BOWLING, MAGGIE ALLEN | | | 2. DATE AND HOUR OF DEATH JANUARY 15, 1971 1:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21228 5300 | | |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER 100 MELVIN AVENUE | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 03/15/85 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIGAR ROLLER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME TATUM | | | 14. MOTHER'S MAIDEN NAME CATHERINE HITE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 224-34-6910 | | 17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES |
| 18. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | (A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Cardiovascular atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Cerebrovascular accident | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 15 years 6 days |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (X) (this hospital) attended the deceased from JANUARY 8 19 71 to JANUARY 15 19 71 that (X) (we) last saw the deceased alive on JANUARY 15 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Bernard L. M.D. | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 01/15/71 |
| 23C. PHYSICIAN'S NAME (Type) BENAVIDES, M.D. | | | 23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 1/18/71 | 24C. NAME OF CEMETERY or CREMATORY GOOD SHEPHERD | | 24D. LOCATION (City, town, or county) (State) HOWARD CO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | 25B. NAME OF REGISTRAR John E. M.D. | | 25C. FUNERAL DIRECTOR 21228 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| V-360 71 0510 | | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0510 | | |
|--|-------------------------|---|--|--|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) KATHLEEN W. VETTER | | | | 2. DATE AND HOUR OF DEATH 1-15-71 9:15 AM | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 45 GOOD SAMARITAN HOSPITAL | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER 924 Dulany Valley Court # 21204 | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-18-96 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Hyattsville, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Clarence Wilson | | | 14. MOTHER'S MAIDEN NAME Mary Frances Palmer | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Walter Vetter-2834 Greenway Dr. # 21043 | | ADDRESS Ellicott City, Md. | |
| 18. 1950 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Disseminate Intraabdominal DUE TO, OR AS A CONSEQUENCE OF: (C) Malignancy | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? — | | (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/15/71 to 1/15/71 , that (I) (we) last saw the deceased alive on 1/15/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | |
| 23A. SIGNATURE [Signature] M.D. | | | | 23B. DATE SIGNED 1/15/71 | | 23C. PHYSICIAN'S NAME (Type) MICHAEL J. PREECE | | |
| 23D. ADDRESS GOOD SAMARITAN HOSPITAL | | 24. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | | |
| 24B. DATE 1-18-71 | | 24C. NAME OF CEMETERY or CREMATORY Western Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Armstrong Funeral Chapel-4600 Liberty | | | | |
| 25D. ADDRESS Hghts Avenue | | | | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0511 | |
|--|--------------------|---|---|--|--|
| W-623 | | 71 0511 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ANNA (Annie) L. WRIGHT | | January 14, 1971 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 2916 Park Wood Ave. | | | A. STATE Maryland | | |
| | | | B. COUNTY 1304 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 2916 Park Wood Ave. | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 5, 1919 | 9. AGE (In years lost birthday) 52 |
| | | | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pineland, S.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME XXXXXXXX William Cohen | | 14. MOTHER'S MAIDEN NAME Gurusha Russell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Henry Wright, 2916 Park Wood Ave. | |
| | | | | ADDRESS | |
| | | | | Henry Wright, 2916 Park Wood Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) 412.3 12250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | |
| | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Cardiac Failure | | | |
| | | (B) MYOCARDITIS - CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) Diabetic | | | |
| | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): Diabetes | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 4 1970 to Dec 12 1970, that (I) (we) last saw the deceased alive on Dec 12 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry Wasserman MD | | DEGREE | | 23B. DATE SIGNED Jan. 16, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Harry Wasserman MD | | DEGREE | | 23D. ADDRESS 1501 Eutaw Place Baltimore, Md. 21217 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Entombment | | 24B. DATE 1/19/71 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Kenneth H. Law | | 25C. FUNERAL DIRECTOR Kenneth H. Law, 4609 Park Heights Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-631 71 0512 BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0512 | |
|--|--|---|--|---|--|
| BIRTH NO. | | REG. NO. | | 71 0512 | |
| 1. NAME OF DECEASED (Type or Print) Brodbeck, Ester | | 2. DATE AND HOUR OF DEATH 1/7/71 1515 p M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Mt. Sinai Nursing Home | | A. STATE Ind. | | B. COUNTY 2798 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 904613 Park Heights Ave. | | C. CITY OR TOWN Baltimore 15 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 6/19/87 | |
| 13. FATHER'S NAME | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | 9. AGE (in years last birthday) 83 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 17. INFORMANT | | ADDRESS | | | |
| 18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Chronic Myocarditis (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Bronchitis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 1967 to Jan 7 1971 that (I) (we) last saw the deceased alive on Jan 5 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louis T. Lavy M.D. | | 23B. DATE SIGNED Jan 7 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY M.D. | | 23D. ADDRESS 3502 W. Rogers Ave Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/14/71 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Barbara E. Taber M.D. | |
| 25C. FUNERAL DIRECTOR W. H. LAW | | 25D. ADDRESS 4609 Park Heights | | | |



1 **R-360** 71 0513 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **71 0513**

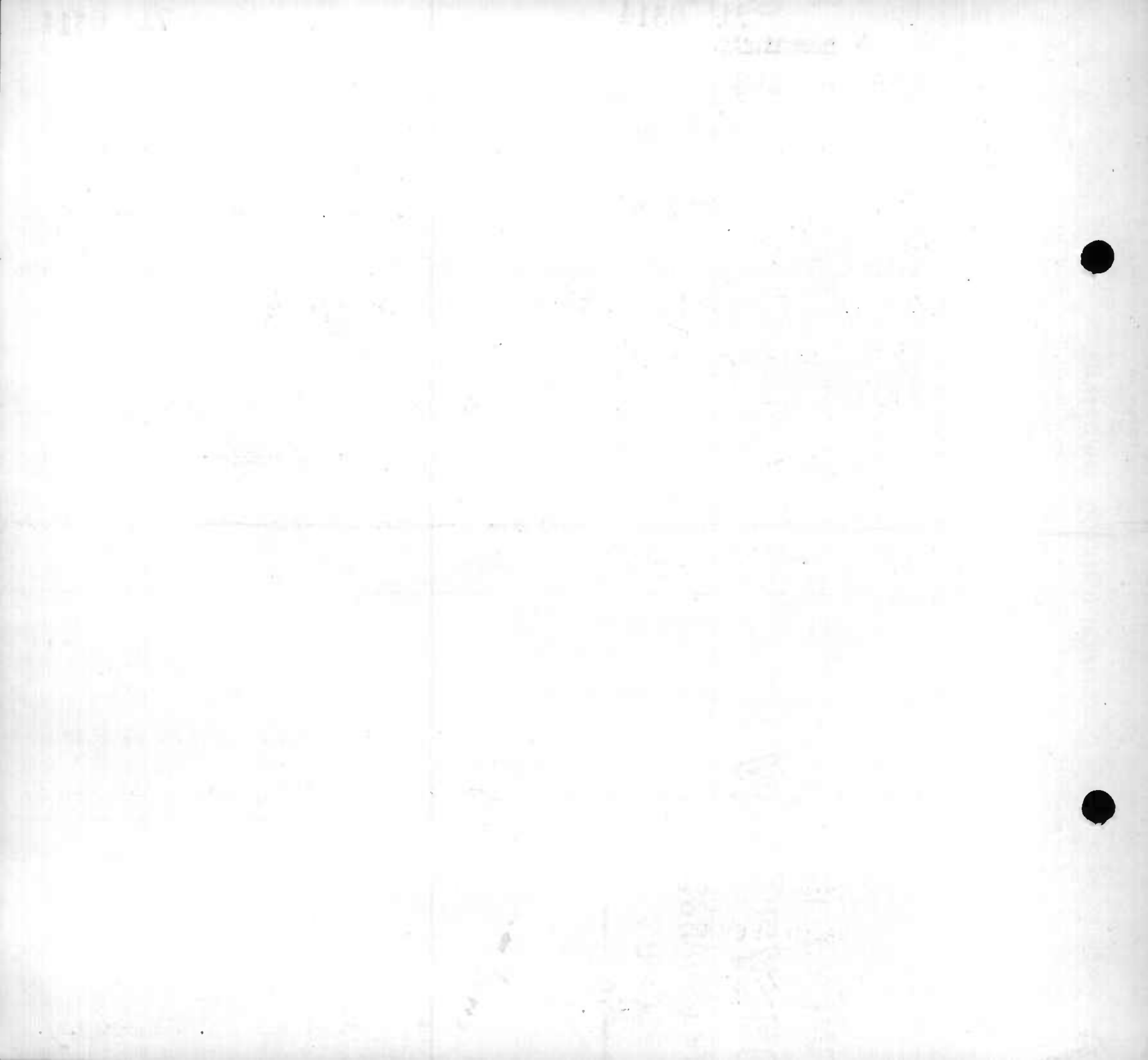
BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) M. ELIZABETH REUTER Mary E. Reuter | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 17 71 3:00 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3130 Fait Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 71 3:00 p.m. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH May 26, 1895 | | 10. AGE (In years lost birthday) 75 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 14B. KIND OF BUSINESS OR INDUSTRY Seamstress | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 213-09-5777 | |
| 18. INFORMANT Mrs Mary Stahl | | ADDRESS Box 175, Route 10, Baltimore | |
| 19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED 1/18/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-21-1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Sacred Heart | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR John J. Zeller | |
| 25C. FUNERAL DIRECTOR Lilly & Zeller Inc. | | ADDRESS 1901-07 Eastern Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-653 71 0514 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0514 | |
|--|------------------------|---|---|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) BRANT, HARRY | | | | 2. DATE AND HOUR OF DEATH JAN 13, 1971 12:05 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Allegany | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital | | | | C. CITY OR TOWN Cumberland | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 135 N. Mechanic Street Apt. 203 | | | |
| 5. SEX M | 6. RACE Cau. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/10/02 | | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance Man | | | 10B. KIND OF BUSINESS OR INDUSTRY Florida | | 11. BIRTHPLACE (State or foreign country) MD. Savage MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Nlyssas Brant | | | 14. MOTHER'S MAIDEN NAME Ida Piper | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Mrs. Virginia Keller. Cumberland MD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTRACRANIAL HEMORRHAGE (B) MAALIGNANT TEMPORAL BONE TUMOR DUE TO, OR AS A CONSEQUENCE OF: (C)..... | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-14 HRS 12-14 MO. | |
| | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN 5 19 71 to JAN 13 19 71 , that (I) (we) last saw the deceased alive on JAN 13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David Leberg | | | | 23B. DATE SIGNED JAN 13, 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) DAVID LEBERG | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/16/71 | | 24C. NAME OF CEMETERY or CREMATORY MD. Savage Mth Cem | | 24D. LOCATION (City, town, or county) (State) MD. Savage Allegany MD | |
| 25A. DATE RECD. IN HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR 0000 | | 25C. FUNERAL DIRECTOR Stein's Funeral Home Inc. Cumberland, Md. | | | |



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM CLAYTON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION
OR INSTITUTION)

38 University Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

Talbot

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

3/18/16

10. AGE (in years
lost birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

112 S. Higgins St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Clayton

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tree Expert

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Hattie Clayton

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

215-26-4682

18. INFORMANT

Harriet Clayton 112 S. Higgins St.

ADDRESS

Easton, Md.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Sepsis

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

shotgun wound of abdomen

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

112 S. Higgins St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

12-28-70

1 p

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Accidentally fell on loaded shotgun.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-11-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/14/71

24C. NAME of CEMETERY or CREMATORY

Richards Mem.

24D. LOCATION

(City, town, or county)

Easton, Talbot

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Easton, Md.

J. E. Dashiell P.O. Box 606

5C Euston, Md.

0120 15

ANDERSON

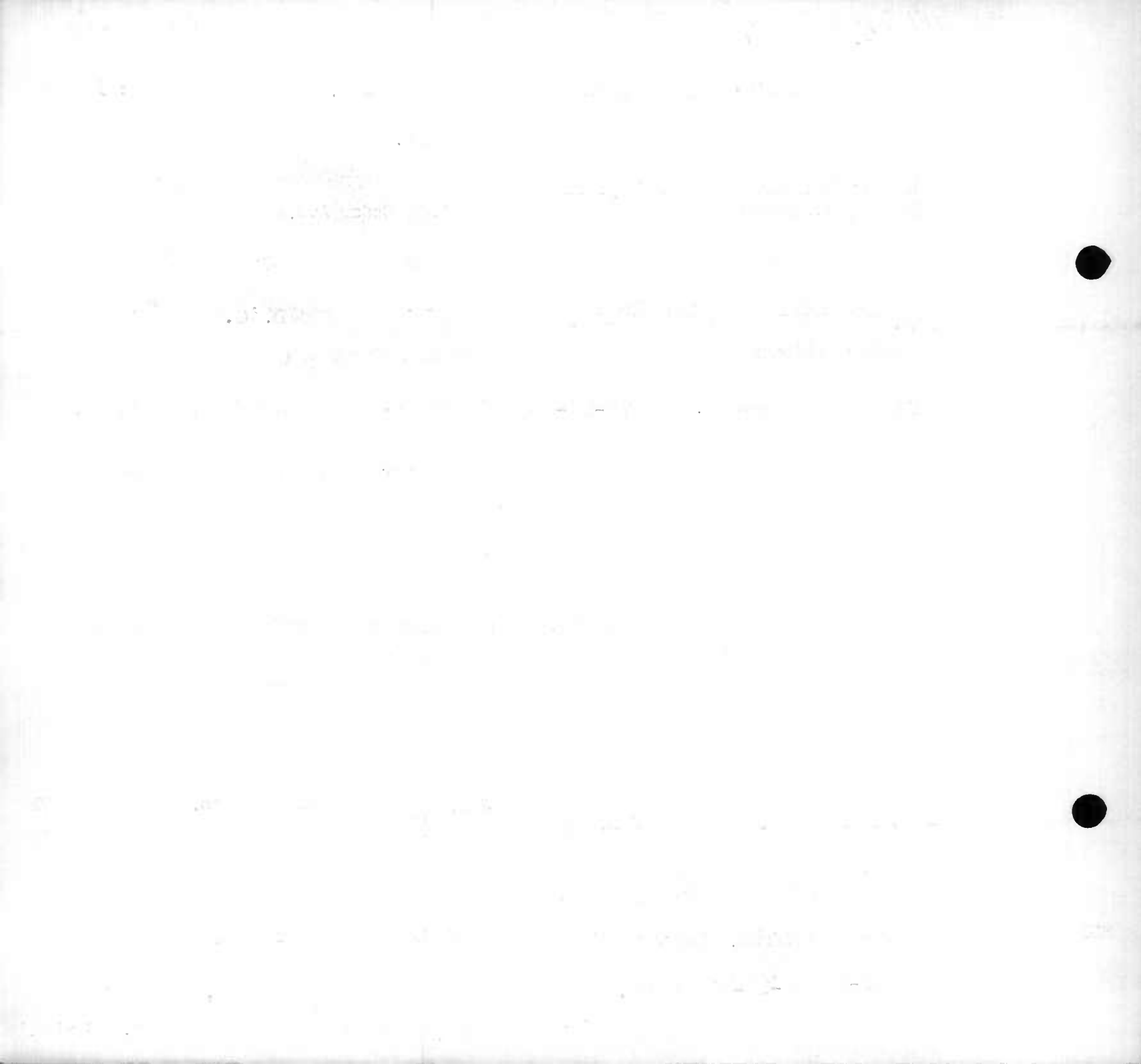
WILLIAMSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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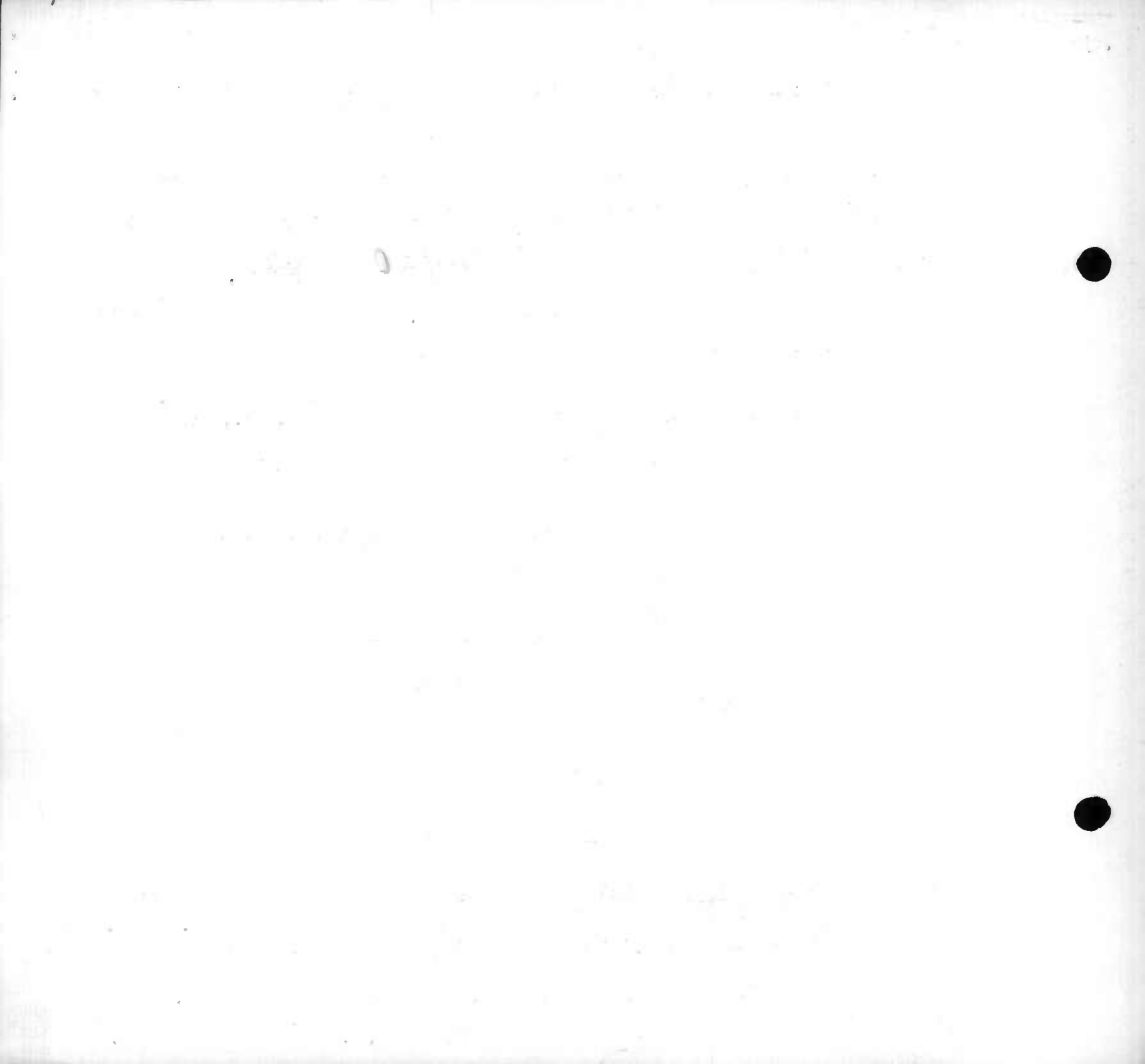
| M-655 | | 71 0516 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 71 0516 | |
|---|--|--|--|---|--|--|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| | | | | Catherine Mary Merryman | | | | Jan. 12, 1971 1:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | | | B. COUNTY | |
| 2X US Public Health Service Hospital 3100 Wyman Parkway | | | | Md. Montgomery 6500 | | | | | |
| | | | | C. CITY OR TOWN | | | | D. INSIDE CITY LIMITS? | |
| | | | | Takoma Park | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | | | |
| | | | | 7209 Cedar Ave. | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | |
| F | | W | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9/4/23 | | 47 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Own Home | | | | Md. Washington, D.C. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| Robert Shipman | | | | Frances Wheat | | | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | |
| NO | | | | None | | | | 579-20-4849 | |
| | | | | Records- US PHS Hospital, Balto, Md. | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE | | | | Myocardial infarct | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | | Days | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | Metastatic undifferentiated carcinoma | | | | Months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | yes | | yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (APPROX.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 10 19 71 to Jan. 12 19 71 that (I) (we) last saw the deceased alive on Jan. 12 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Gary E. Feldman, Surgeon (R) | | | | 1/13/71 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Gary E. Feldman, Surgeon (R) | | | | US PHS Hospital, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Removal | | 1-16-71 | | Natl. Memorial Park | | Falls Church, Virginia | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR'S ADDRESS | | | | | |
| JAN 19 1971 | | R. E. Feldman | | Green Funeral Home, Herndon, Virginia | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0517 | |
|--|---------------|---|-----------------------------|--|--|
| F-652 | | 71 0517 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) FRANCIS, BERNARD | | 2. DATE AND HOUR OF DEATH 1/14/71 7:30 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore | | C. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 734 Lennox St 21217 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/17/20 | 9. AGE (In years last birthday) 50 yrs. | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) porter | | 10B. KIND OF BUSINESS OR INDUSTRY Hochschild Kohn | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME EARL Francis | | 14. MOTHER'S MAIDEN NAME VIOLETA Grayson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 2-1-43 11-17-45 | | 16. SOCIAL SECURITY NO. 216-18-7767 | | 17. INFORMANT Augusta Grooms BCH Records: 4940 Eastern Ave. Balto. Md., 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E887X1 CAUSE OF DEATH 40% 3 rd degree BURN (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEIZURE (B) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) PNEUMONIA | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) WORK | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1-10-71 | | 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? not aware of work & fell under | | 22. I certify that (I) (this hospital) attended the deceased from 1/10/71 to 1/14/71 that (I) (we) last saw the deceased alive on 1/14/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Gunduz Gucer | | 23B. DATE SIGNED 1/14/71 | | 23C. PHYSICIAN'S NAME (Type) GUNDUZ GUCER | |
| 23D. ADDRESS 4940 Eastern Ave. Balto. Md. 21224 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-19-71 | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | |
| 25B. NAME OF REGISTRAR V. Bailey | | 25C. FUNERAL DIRECTOR Relson F.H. | | 25D. ADDRESS 1348 Calhoun St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-300 | | 71 0518 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0518 | |
|---|-------------------------|---|-----------------------------------|--|---|---|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Scott, Leroy</u> | | | | 2. DATE AND HOUR OF DEATH <u>January 15th 1971</u> <u>12:45 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1801</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>129 N. Schroeder St.</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/2/29</u> | 9. AGE (in years last birthday) <u>42</u> | 10. Under 1 Yr. Months: Days: <u>42</u> | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboren</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | | 11. BIRTHPLACE (State or foreign country) <u>South Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>EMERSON Scott</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LYDIA P</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>IDA SCOTT</u> | | ADDRESS <u>Same as above</u> | |
| 18. <u>782.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>1</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (INJURY OCCUR (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January 13th 1971</u> to <u>January 15th 1971</u> that (I) (we) last saw the deceased alive on <u>January 15th 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>J. C. L.</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/15/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JUAN M. CABRERA M.D.</u> | | | | 23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Shipped</u> | | 24B. DATE <u>1/20/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Suffolk Va.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Suffolk Va.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.A.</u> | | 25C. FUNERAL DIRECTOR <u>William's General Home</u> | | ADDRESS <u>399 Schroeder St.</u> | |

UNIVERSITY OF MARYLAND REGISTER

12 N. 2nd St. B

Lafayette

2nd Grade

Enrollment 200

1st 1

190

1st 200

1/2 1/2 42

Shipped 1/20/11 by express for
William F. Smith & Co. Baltimore, Md.

B-300 71 0519 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **71 0519**

| | | | | | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Portia Reed | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 18 71 11:47 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 71 11:47 a.m. | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1402 | |
| 6. SEX female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH x6x27x | | 10. AGE (In years last birthday) 21 | 11. BIRTHPLACE (State or foreign country) Baltimore M. | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 14B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME Willie Wyatt | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 15. MOTHER'S MAIDEN NAME Elizabeth Reed | |
| 18. INFORMANT M's Elizabeth Reed, Same | | ADDRESS | | | |
| 19. 304.2 | | CAUSE OF DEATH Barbiturate overdose | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Interstitial pneumonitis & subacute hepatitis | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown | |
| 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 1-18-71 Unknown m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Said to be an addict | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 23. Friends stated she took some dummies | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 1/18/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | | 24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) A A County M | | 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Halstead | |
| 25C. FUNERAL DIRECTOR Halstead 1206 W North Ave | | 25D. ADDRESS | | | |

3/1/71 - Letter from M.E. O.

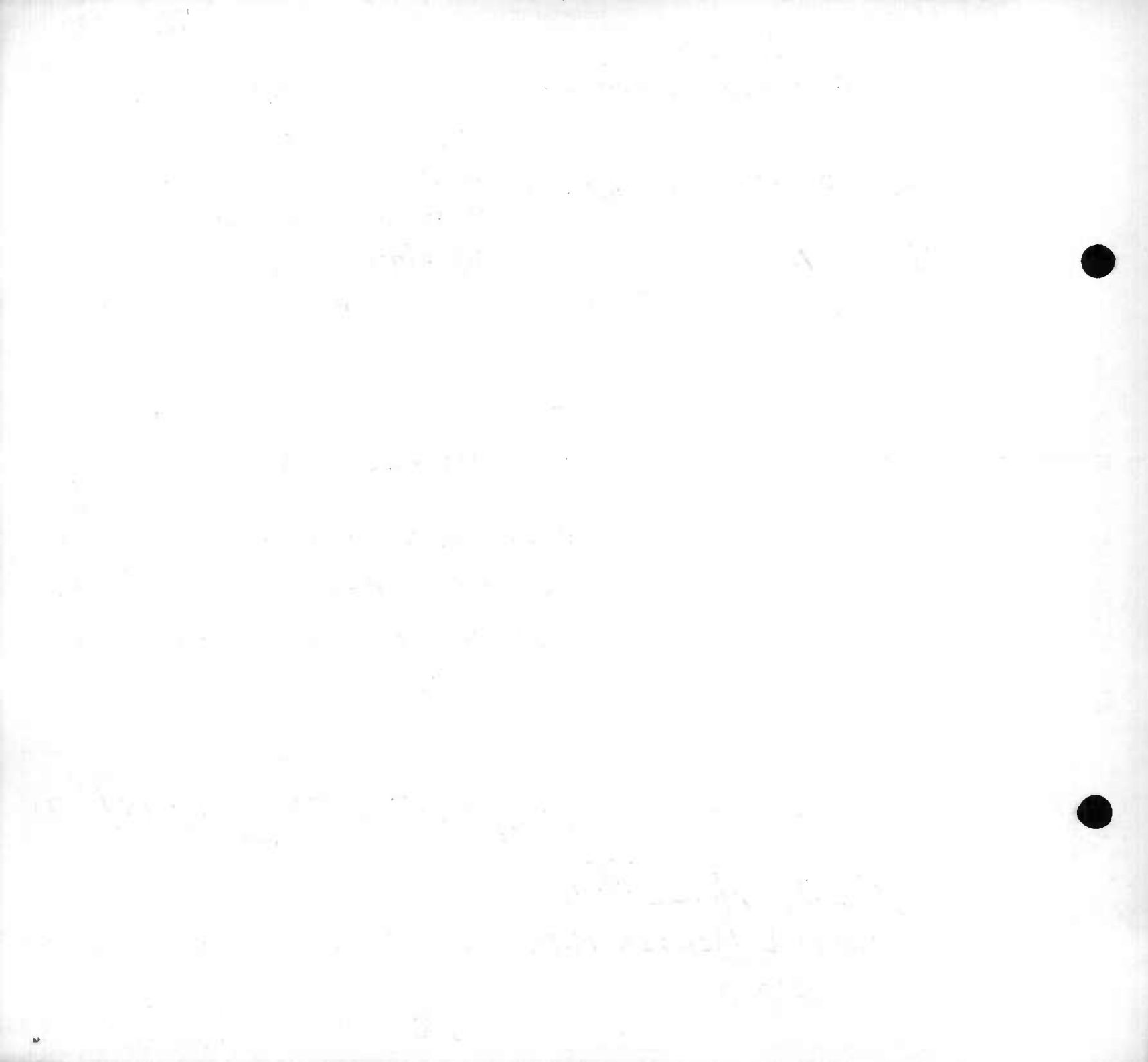
ABC

Letter from M.E.'s office

3-25-71 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

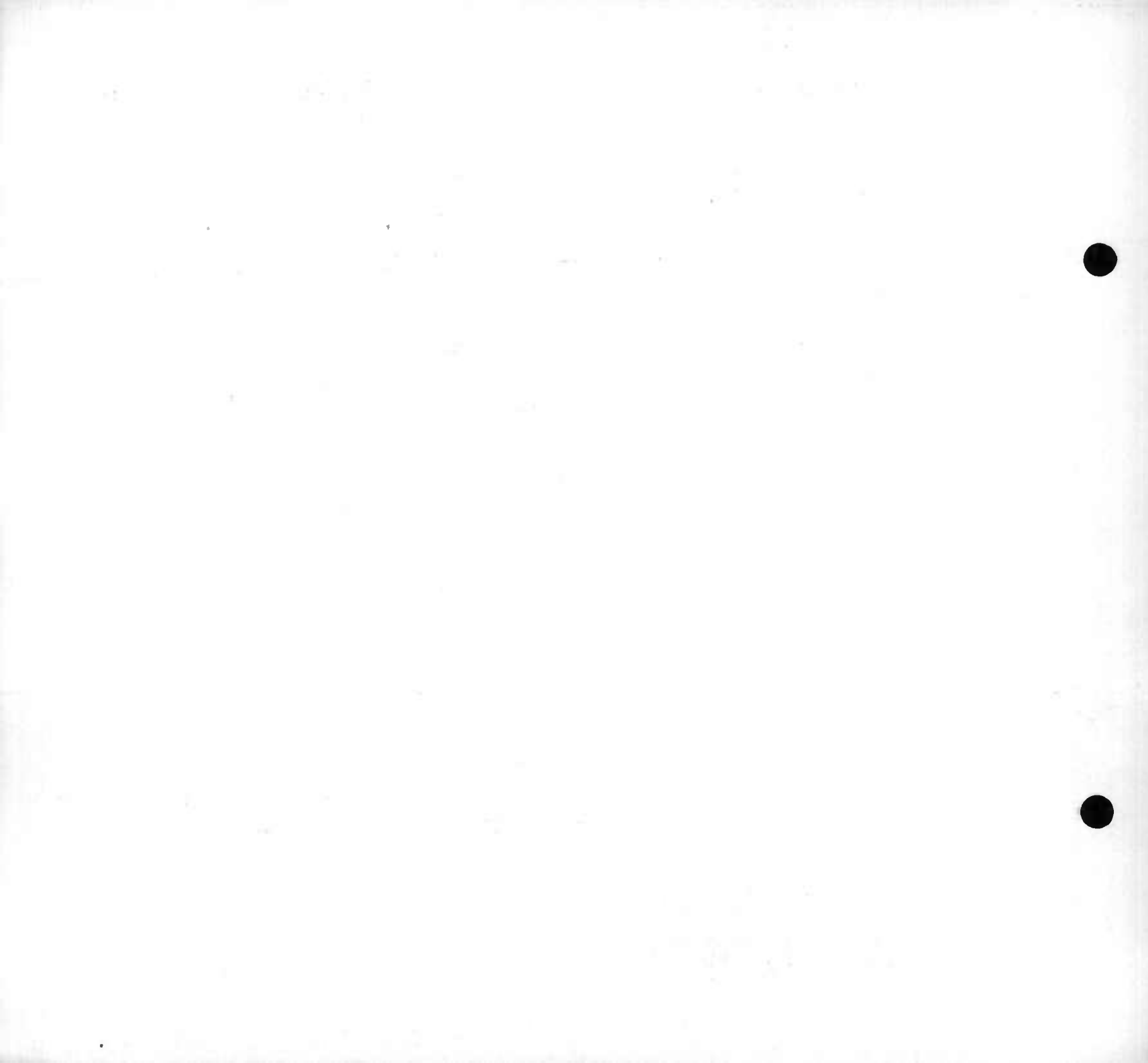
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------|--|---|--|---|
| 71 0520 | | 71 0520 | | 71 0520 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HUTCHISON, CLEVELAND | | 1/15/71 10 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| SINAI HOSPITAL OF BALTIMORE | | | MD. BALTO. 1512 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 3923 PARK HEIGHTS AVE. | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months Days |
| M | N | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 6/18/97 | 73 | 11 Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | Chemical | | Georgetown, S C | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| George Hutchison | | | U S A | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 14. MOTHER'S MAIDEN NAME | | |
| no | | | Nether | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| 185-01-6452 | | | A M's Celie Mae Hutchison, Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | GRAM NEGATIVE SEPSIS | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DECUBITUS ULCER OF FOOT | | |
| | | | (C) DIABETES MELLITUS | | |
| II | | | URINARY TRACT INFECTION | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | 1 day | | |
| | | | 2 mon. | | |
| | | | many years | | |
| | | | 1 wk | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/7/1970 to 1/15/1970 and that (I) (we) lost saw the deceased alive on 1/15/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Albert L. Menner M.D. | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| ALBERT L. MENNER M.D. | | | | 6215A PIMLICO RD. BALTO. 21207 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/21/71 | | MT Calvary Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 19 1971 | | Robert L. ... | | A. A. Harstead | |
| | | | | ADDRESS | |
| | | | | 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|--|--|
| D-120 71 0521 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0521 | |
| 1. NAME OF DECEASED (Type or Print) Stella DAVIS | | 2. DATE AND HOUR OF DEATH 1/16/71 5:20 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Century Home Inc 102 N Paca St. Balto Md | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland B. COUNTY 1602 | |
| 5. SEX F | | 6. RACE N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old Age | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 6/27/81 9. AGE (in years last birthday) 89 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | |
| 13. FATHER'S NAME James Dixon | | 14. MOTHER'S MAIDEN NAME Annie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215 12 2632 | | 17. INFORMANT Mrs Grace McLean, some | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Vascular Accident Arteriosclerotic CVD Gen + Cerebral Arteriosclerosis | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 7 1970 to Jan 16 1971 that (I) (we) last saw the deceased alive on Jan 7 1971 and that (in my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>William D Applefeld</i> | | | | 23B. DAY SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) William D Applefeld MD | | | | 23D. ADDRESS 6615 Neustetter Rd | |
| 24A. BURIAL, CREMATION, or other disposal (Specify) | | 24B. DATE 1/23/71 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION (City, town or county) (State) A A County Md | | 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | | |
| 25B. NAME OF REGISTRAR John E. Kelly MD | | 25C. FUNERAL DIRECTOR A O Halstead | | | |
| ADDRESS 1206 W North Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

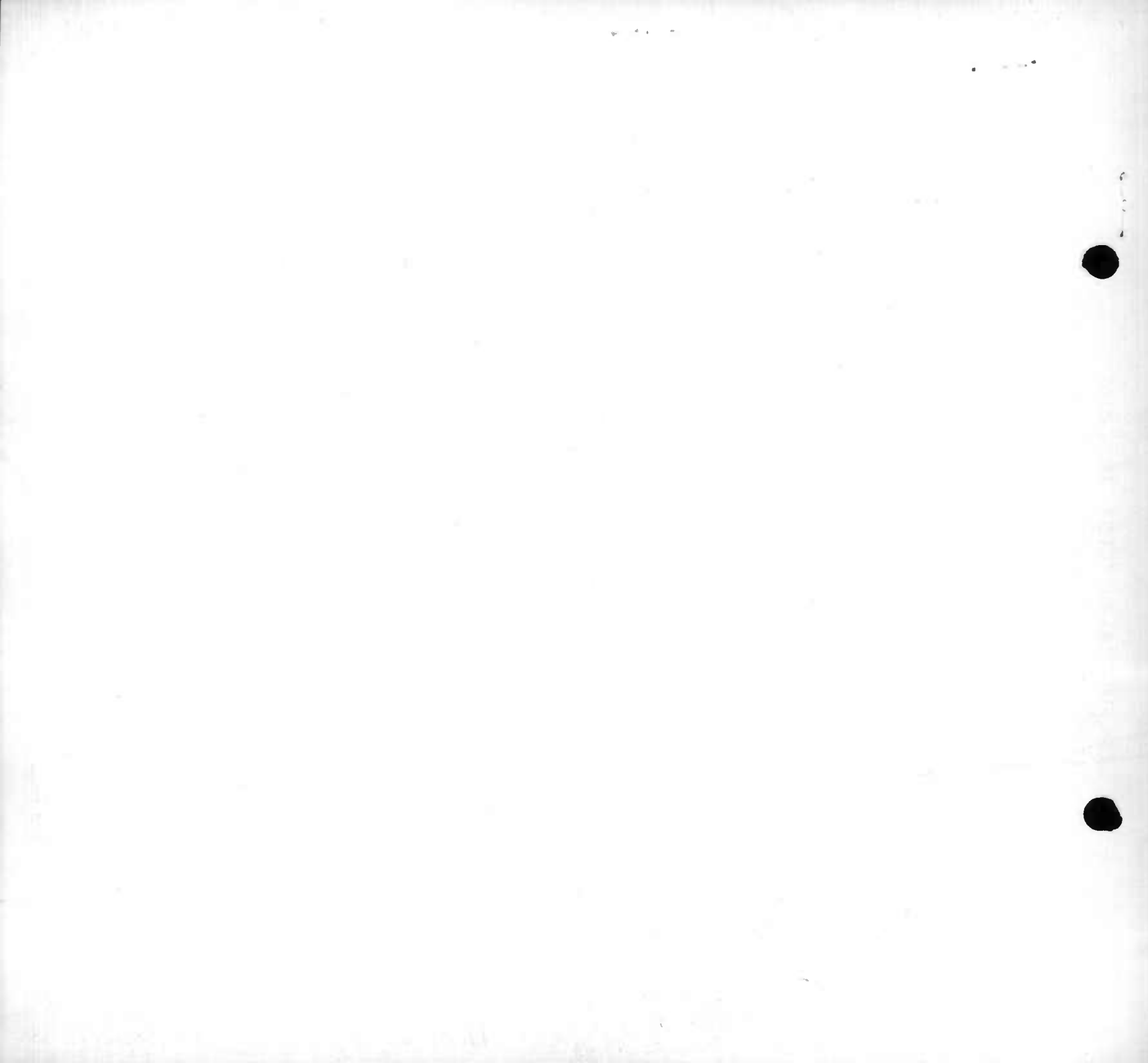
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | |
|---|-------------------------|---|---|---|---|---|---|---|--|--|
| BIRTH NO. 71 0522 | | | | | REG. NO. 71 0522 | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Rogers Mr. Tom</u> | | | | | 2. DATE AND HOUR OF DEATH <u>January 17, 1971 7:05 P.M.</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOUR HOSPITAL</u> <u>34</u> | | | | | A. STATE <u>MARYLAND</u> | | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | B. COUNTY <u>BALTIMORE</u> | | | | | |
| | | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | E. STREET AND NUMBER <u>508 N. FULTON AVE. 1604</u> | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Black</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-10-1901</u> | 9. AGE (In years lost birthday) <u>69</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | 11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>HENRY ROGERS</u> | | | 14. MOTHER'S MAIDEN NAME <u>FANNY GEE</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u> | | | 16. SOCIAL SECURITY NO. <u>244-18-8414</u> | | 17. INFORMANT <u>Mrs. Ruby Rogers</u> | | | | ADDRESS <u>508 N. FULTON AVE</u> | |
| 18. <u>183 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>SEPTICEMIC SHOCK</u> <u>Ca of Prostate Gland enlargement Undetermined</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | |
| | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>(R) Lower Pneumonia</u> | | | | | |
| | | | | | (C) _____ | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> 19 <u>71</u> to <u>Jan 17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>7:05 pm Jan 17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Manuel Baldos</u> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>Jan 17/71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Manuel Baldos</u> | | | | | 23D. ADDRESS <u>Morton E. Dyett F.H. 1701 Laurens St.</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/23/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balt.</u> <u>Maryland</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1971</u> | | 25B. NAME OF REGISTRAR <u>Ruby E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Morton E. Dyett F.H. 1701 Laurens St.</u> | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0523 | |
|--|--|---|--|--|--|
| 71 0523 | | | | 71 0523 | |
| BIRTH NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) WILSON EDDIE A. | | | | 2. DATE AND HOUR OF DEATH 1.18.71. 5.45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 730 Ashburton Street Baltimore 21216 | | | | A. STATE MARYLAND B. COUNTY 1607 | |
| | | | | C. CITY OR TOWN Baltimore | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3232 NORMOUNT AVENUE | |
| 5. SEX M. | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11.21.09 | 9. AGE (In years last birthday) 61 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA |
| 13. FATHER'S NAME Robert Wilson | | | 14. MOTHER'S MAIDEN NAME Margaret Wilson | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | | 16. SOCIAL SECURITY NO. 217-03-4260-A | | 17. INFORMANT Mrs. Gladys Wilson ADDRESS 3232 Normount Ave |
| 18. E880X1 CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fracture base of Skull | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | (C) | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 16-07 | |
| 21D. TIME OF INJURY (APPROX.) 1.1.71 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fall from steps of his house | |
| 22. I certify that (I) (this hospital) attended the deceased from 1.1.71 19 to 1.18 1971 | | | | | |
| that (I) (we) lost saw the deceased alive on 1.17 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rajivendra Rao DEGREE M.D. | | | | 23B. DATE SIGNED 1.18.71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. R. Govinda Rao DEGREE M.D. | | | | 23D. ADDRESS Lutheran Hospital of Maryland 730 Ashburton Street Baltimore 21216 | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | 24B. DATE 1/23/71 | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR R. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Horton E. Dyett F.H. 1701 Laurens St. | |



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71 0524

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0524

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) A. Wesley Austin | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1/ Day 18 Year 71 Hour 4:10 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 114 N. Monastery Avenue | | 3. DATE PRONOUNCED DEAD Month 1 Day 18 Year 71 Hour 4:10 a.m. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8-14-1889 | | 10. AGE (In years, lost birthday) 81 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Blackstone, Virginia | | 12. CITIZEN OF U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Mrs. Louise Hicks | | ADDRESS 114 N. Monastery Avenue | |
| 19. CAUSE OF DEATH 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) no | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/18/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-22-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Cellar Creek Bapt. Ch. Cem. | | 24D. LOCATION (City, town, or county) (State) Blackstone, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR MORTON & DYETT F.H. | | ADDRESS 1701 Laurens Street | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 71 0525 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0525 | |
|--|---------------|--|-----------------------------|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Conway James G Sr. | | 1-16-71 9:40 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| North Charles General Hospital | | Md. 2401 E. STREET AND NUMBER 1453 Stevenson ST. BALto 21230 | | | |
| 5. SEX M | 6. RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-12-11 | 9. AGE (in years last birthday) 59 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Grocer-Luckhart Self Employed Grocer | | BALto - Md. | | BALto - Md. | |
| 13. FATHER'S NAME FRANK Conway | | 14. MOTHER'S MAIDEN NAME Caroline Luckhardt | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-01-2567 | | 17. INFORMANT Chart- | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes (C) DUE TO, OR AS A CONSEQUENCE OF: Diabetes | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-16-71 to 1-16-71 that (I) (we) last saw the deceased alive on 9:40 AM 1-16-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | 23B. DATE SIGNED 1-16-71 | | 23C. PHYSICIAN'S NAME (Type) [Signature] | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/20/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. ADDRESS Anne Arundel, Md. | | 24F. FUNERAL DIRECTOR Stevens Funeral Home, Inc. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Robert E. Taber, M.D. | | 25C. FUNERAL DIRECTOR 4501 East Fort Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0526 | |
|--|--|---|---|---|---|
| M-624 71 0526 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Marshall, Mattie</i> | | 2. DATE AND HOUR OF DEATH <i>January 18/71 4:35 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1603</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital of Md</i> <i>46</i> | | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <i>F</i> 6. RACE <i>N</i> | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>6-18-80</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years last birthday) <i>90</i> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-10-2926</i> | | 17. INFORMANT <i>Milton Wheeler</i> ADDRESS <i>3402 W. Saratoga</i> | |
| 18. <i>486X1</i> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-21-70</i> to <i>1-18-71</i> 4:35 PM that (I) (we) last saw the deceased alive on <i>1-18-71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | | 23B. DATE SIGNED <i>1-18-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Nasser SAGHAEL, M.D.</i> | | | | 23D. ADDRESS <i>Lutheran Hosp. of Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/21/71</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1971</i> | | | |
| 25B. NAME OF REGISTRAR <i>[Signature]</i> | | 25C. FUNERAL DIRECTOR'S ADDRESS <i>Keelson F.H. 1348 N. Calhoun St.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 0527 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0527 | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) DUFF, ALONZO | | | | 2. DATE AND HOUR OF DEATH 1/18/71 6:58 AM | | | | M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1604 | | | | C. CITY OR TOWN Baltimore | | | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | E. STREET AND NUMBER 800 N. Monroe Street 21217 | | | | | | | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/11/02 | | 9. AGE (In years last birthday) 68 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) N. C. | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Milus | | | | 14. MOTHER'S MAIDEN NAME Lula | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk. | | | | 16. SOCIAL SECURITY NO. 220-03-6922A | | | | 17. INFORMANT ADDRESS BCHRecords: 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 7-12-41 arteriosclerotic cardiovascular disease CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased, from January 9 1971 to January 18 1971 that (I) (we) last saw the deceased alive on 1/18 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Joseph Roll M.D. | | | | 23B. DATE SIGNED 1/18/71 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Joseph Roll, M.D. | | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71 | | 24C. NAME of CEMETERY or CREMATORY Sutton Cem. | | 24D. LOCATION (City, town, or county) (State) Northumberland Co., Va. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Kelson F.H. | | 25D. ADDRESS 1348 N. Calhoun St. | | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Mabel E. Spence | | 2. DATE AND HOUR OF DEATH 1/17/71 5:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1202 | | C. CITY OR TOWN Baltimore | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 4-6-1892 | | 9. AGE (In years last birthday) 78 | | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary Ret'd. | | 10B. KIND OF BUSINESS OR INDUSTRY University Hospital | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John B. Spence | | 14. MOTHER'S MAIDEN NAME Jane McCullough | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-05-8670 | | 17. INFORMANT ADDRESS 21201 Mr. Julius Novey 912 Fidelity Bldg. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH RENAL RESPIR. FAILURE Gastric Pneumonia CA OF LUNG TUMOR | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 DAYS (?) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 1/9 1971 to 1/17 1971 that (we) lost saw the deceased alive on 1/17 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. M. Pardo MD | | 23B. DATE SIGNED 1/17/71 | | 23C. PHYSICIAN'S NAME (Type) Mabel E. Spence MD | |
| 23D. ADDRESS 4905 York Road Balto., Md. | | 23E. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. | | 23F. ADDRESS 4905 York Road Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-20-71 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 24F. NAME OF REGISTRAR Robert E. Jenkins | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

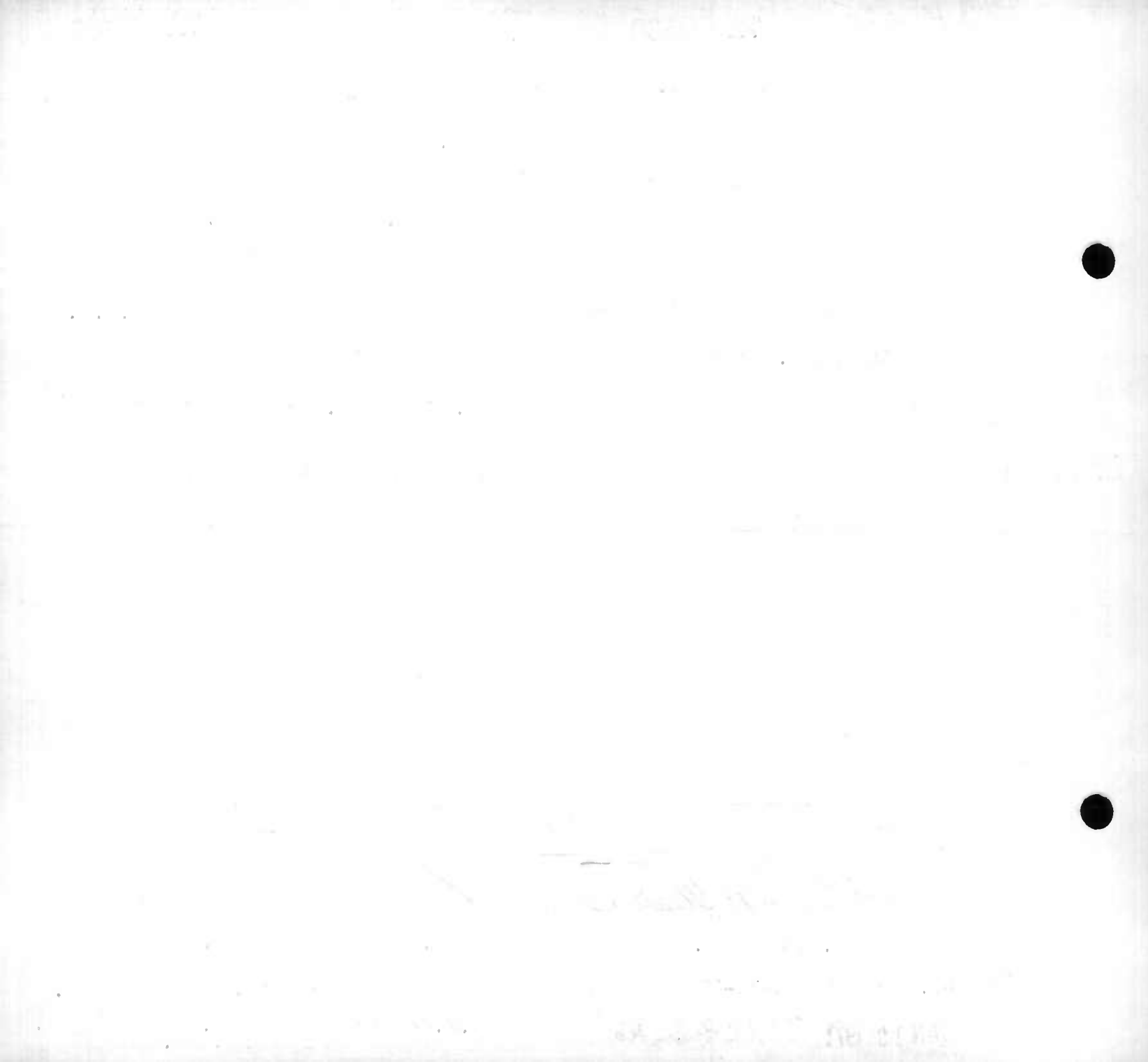
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0529 | |
|--|--|--|---|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) MAY R. TRAVERS | | 2. DATE AND HOUR OF DEATH 1-17-71 1:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MD. GEN. HOSP. 48 P27 LINDEN AVE. | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY 2759 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1420 Kingway Rd. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-14-87 | 9. AGE (in years last birthday) 83 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOLTEACHER | | 10B. KIND OF BUSINESS OR INDUSTRY EDUCATION-SCHOOL | | 11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HENRY CLAY TRAVERS | | | 14. MOTHER'S MAIDEN NAME MARY WALL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220447108 | | 17. INFORMANT OLIVER S. TRAVERS, SR. ADDRESS 516 WILTON RD. 21204 | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Chronic atherosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: chronic atherosclerotic cardiovascular disease (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-17 19 71 to 1-17 19 71 that (I) (we) last saw the deceased alive on 1-17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leo A. Courtney MD | | | | 23B. DATE SIGNED 1-17-71 | |
| 23C. PHYSICIAN'S NAME (Type) LEO A. COURTNEY MD | | 23D. ADDRESS 827 LINDEN AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-21-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 25B. NAME OF REGISTRAR Robert E. Jenkins | | | |
| 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212 | | | | VS 150-REV. 1/1/68 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

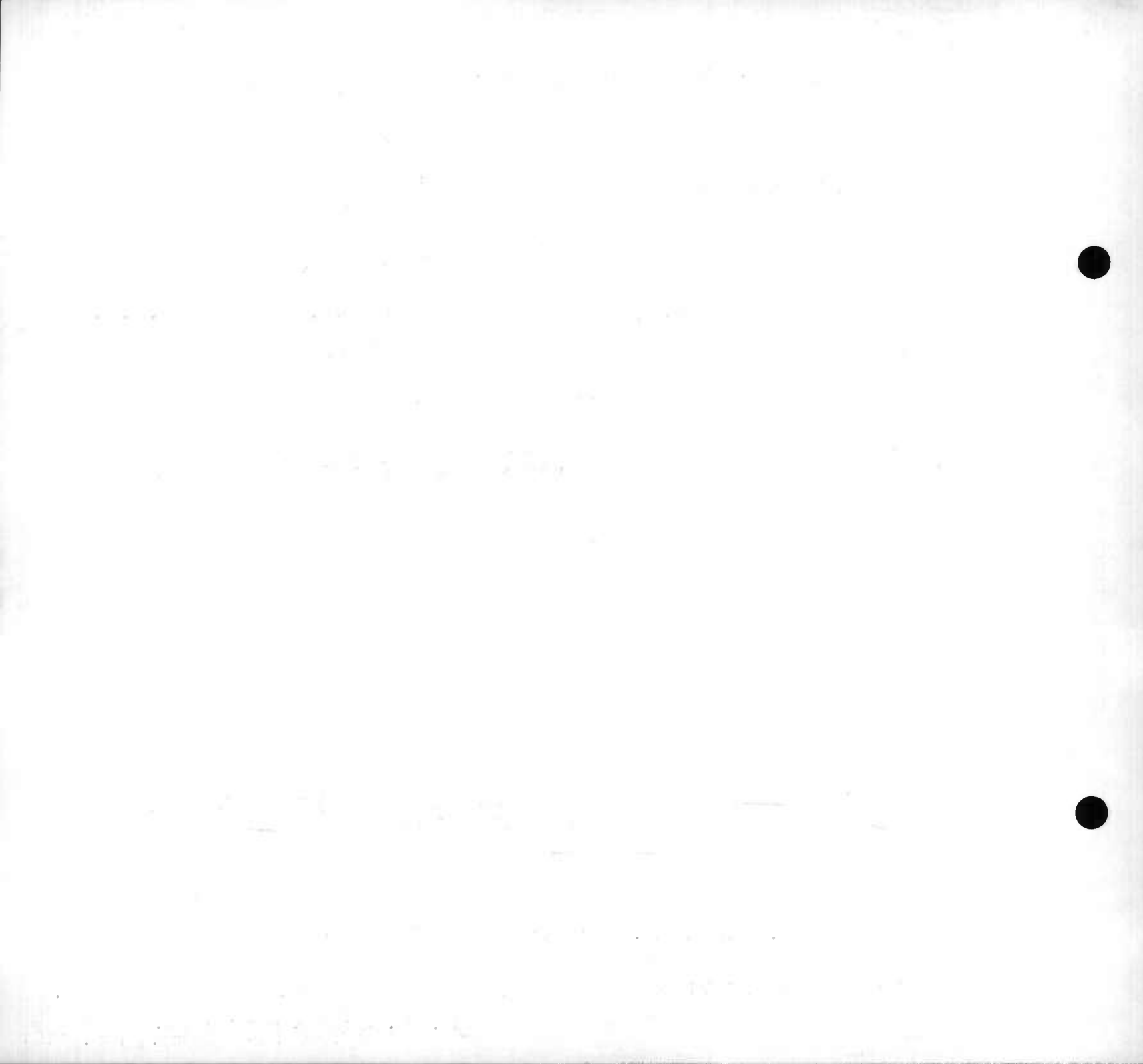
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0530 | |
|--|--------------|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> L-535 71 0530 71 0530 </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Martha M. Landon | | 1-16-71 11:30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Northway Apartments | | | A. STATE Md. | | |
| | | | B. COUNTY | | |
| 00 | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 3700 N. Charles St. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-16-1901 | 9. AGE (in years last birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Richard K. Meade | | | 14. MOTHER'S MAIDEN NAME Fannie | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Joseph W. Hogue 2 Hopkins Place | |
| ADDRESS 21203 | | | | | |
| 18. 413.21 CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>Hypertensive ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/7/46</u> 19 to <u>1/16/71</u> 19 that (I) (we) last saw the deceased alive on <u>1/16/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Francis W. Gluck MD</u> | | | | 23B. DATE SIGNED <u>1/18/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Francis W. Gluck | | | | 23D. ADDRESS 100 W. University Pkwy. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Rem. Burial | | 1-21-71 | | Elmwood Cemetery | |
| 25A. DATE RECD BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 19 1971 | | Robert E. Jenkins | | H.W. Jenkins Sons & Co. 4905 York Rd. Baltimore, Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

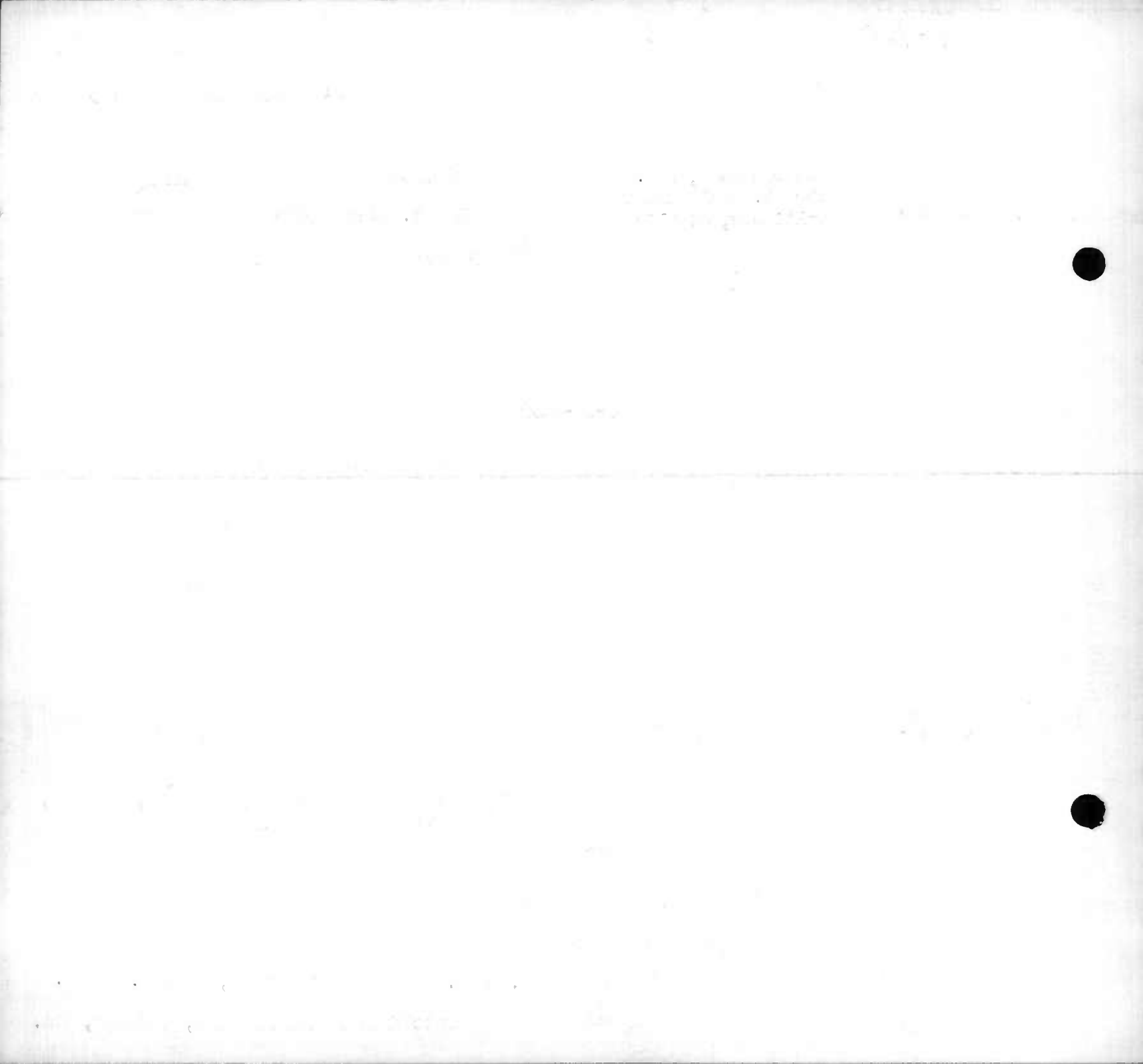
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0531 | | 71 0531 | |
|---|------------------|---|--|---|---|--|--|
| BIRTH NO. <u>M-242</u> | | | | 71 0531 | | REG. NO. <u>71 0531</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Sr. Mary Bernard O.S.F.</u> <u>Lillian Regina McLaughlin</u> | | | | 2. DATE AND HOUR OF DEATH <u>Jan. 16, 1971</u> <u>9:20 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>94 Franciscan Motherhouse</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>901</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3725 Ellerslie Avenue</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-9-1894</u> | 9. AGE (In years last birthday) <u>76</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nun</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nun</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Religious</u> | | 11. BIRTHPLACE (State or foreign country) <u>Norfolk, Va.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Richard McLaughlin</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Prince</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>230-70-0700</u> | | | 17. INFORMANT <u>Sister Mary Alexander</u> ADDRESS <u>3725 Ellerslie Ave</u> | | | | |
| 18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anteriosclerotic C.V. Disease</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>Jan. 15th</u> 19 <u>60</u> to <u>Dec. 28th</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>Dec. 28th</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We)</u> (did) <u>(did not)</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Dr. William H. Kammer</u> | | | | 23B. DATE SIGNED <u>1-18-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Dr. William H. Kammer</u> | |
| 23D. ADDRESS <u>6011 York Road</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>1-19-1971</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Convent Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1971</u> | |
| 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR <u>OH 5W Jenkins & Sons Co.</u> | | 25D. ADDRESS <u>4905 York Road Balto., Md. 21212</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

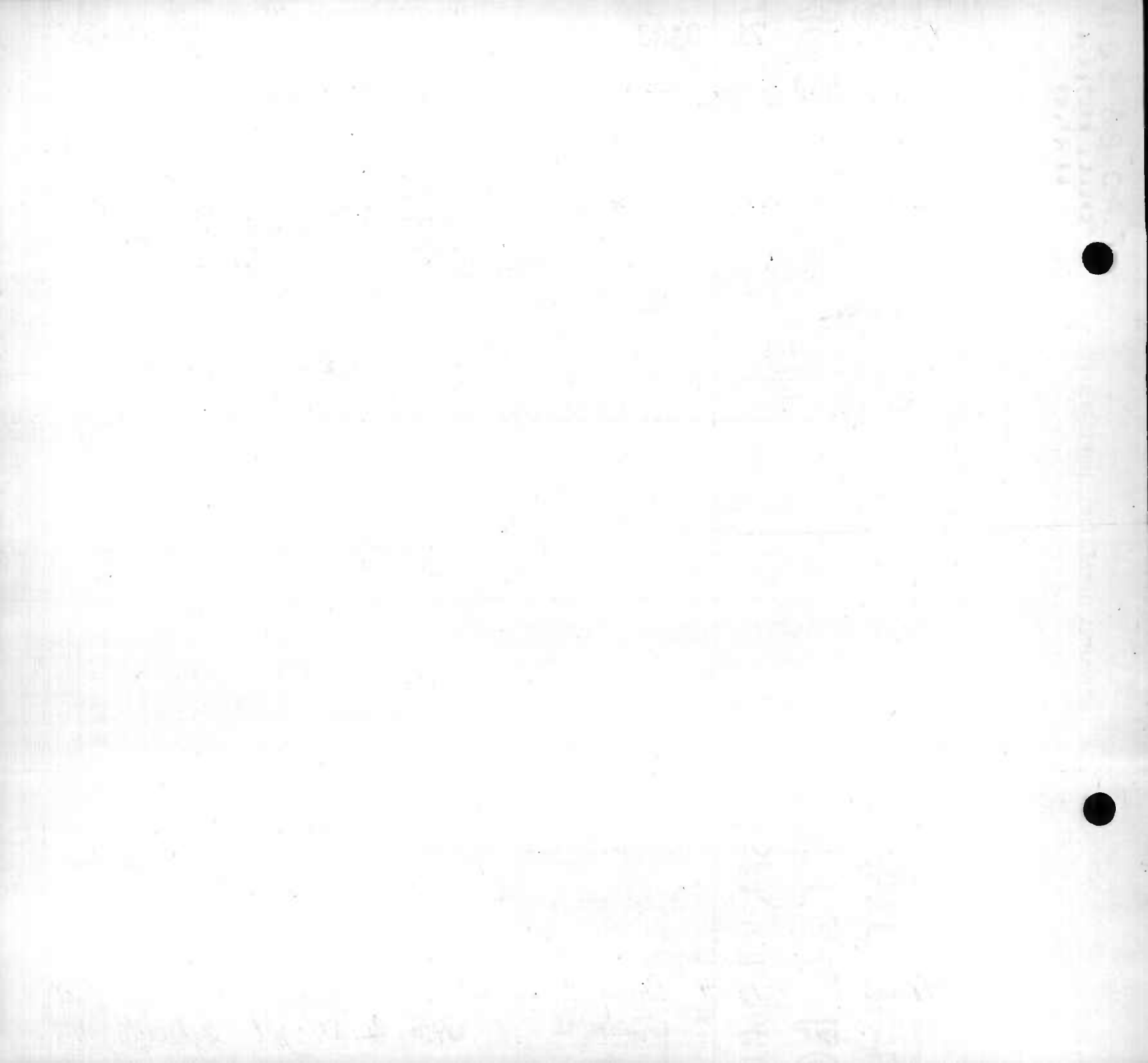
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0532 | |
|--|--|---|--|---|---|
| F-460 71 0532 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mary FOWLER | | 2. DATE AND HOUR OF DEATH January 13 1971 7:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home, Inc. 808 St. Paul Street Baltimore, Md 21202 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 1102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 816 St. Paul Street | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/22/88 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-38-6259 | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Respiratory Failure Cerebral Vascular Accident Arteriosclerosis EVHD | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: Gen & Cerebral Arteriosclerosis | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 7 1961 to Jan 13 1971 that (I) (we) last saw the deceased alive on Jan 13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Melvin Applefeld | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) William D Applefeld | |
| 23D. ADDRESS 6615 Reisterstown Rd | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY Mirandq Memo. Cem. | | 24D. LOCATION (City, town, or county) (State) Huntingtown, Cal. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Robert E. Gubay | | 25C. FUNERAL DIRECTOR Dutchins Funeral Home, Owings, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

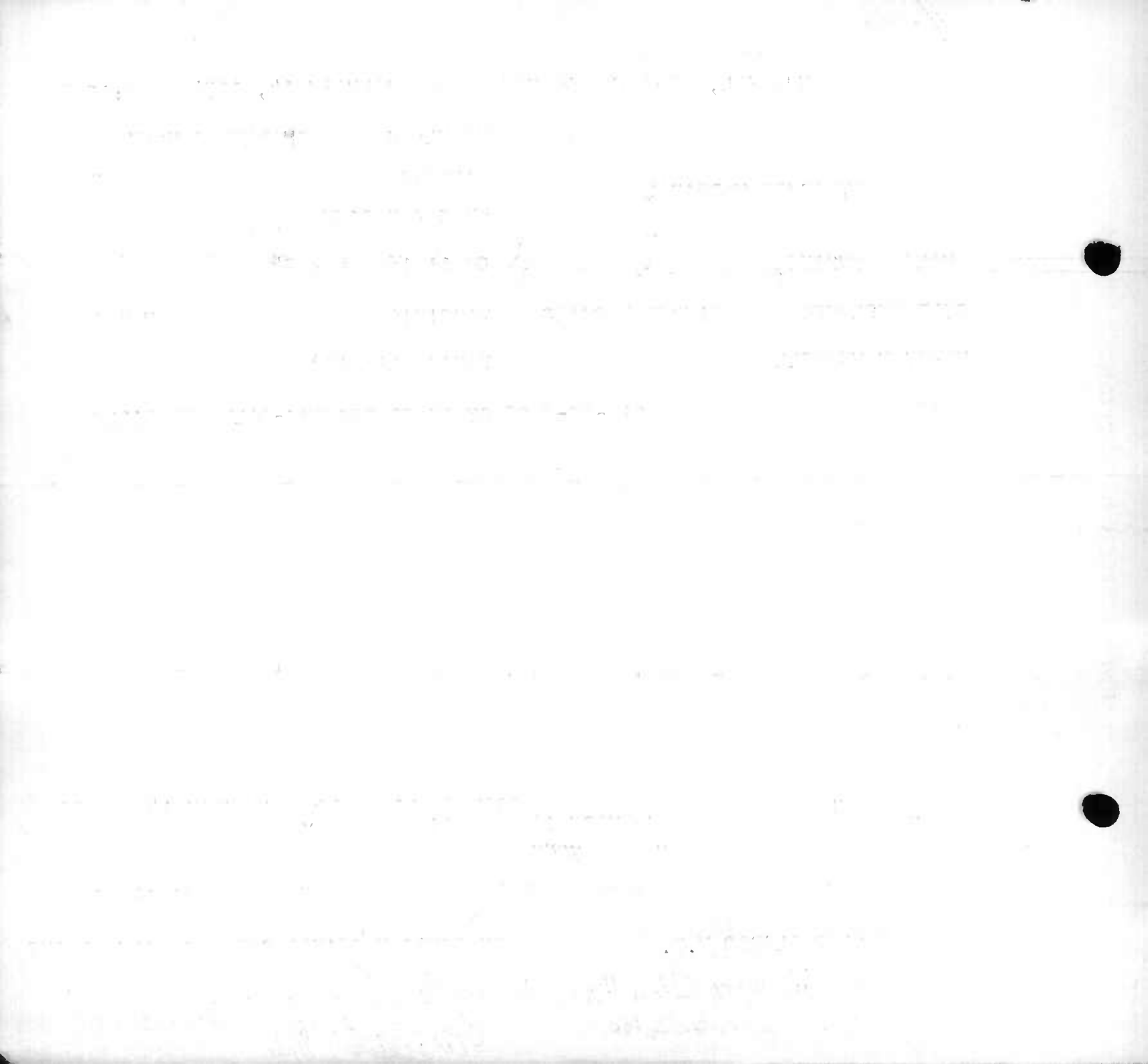
| | | | | | | | |
|--|---------|--|------------------|--|-----------------------|--|-----------------------|
| P-400 | | 71 0533 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0533 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| POWELL, Walter | | | | 2. DATE AND HOUR OF DEATH 1/15/71 5:00 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| The Johns Hopkins Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 1231 Division Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| Male | Negro | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 4/01/89 | 81 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| LABORER | | FARM | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Unk. | | | | Unk. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 219 12 6192 | | Mrs. Ida Williams | | West Friendship, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | Brown Stem Stroke | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| Coronary reperi + bilateral pneumonia | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/9 1971 to 1/15 1971, that (I) last saw the deceased alive on 1/14 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Henry D. Ziegler MD | | | | 1/15/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Henry D. Ziegler MD | | | | Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 1-18-71 | | Daisy Church Cemetery | | Howard Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 19 1971 | | Robert E. Ziegler MD | | Wm. W. Haight | | Lysaoville, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

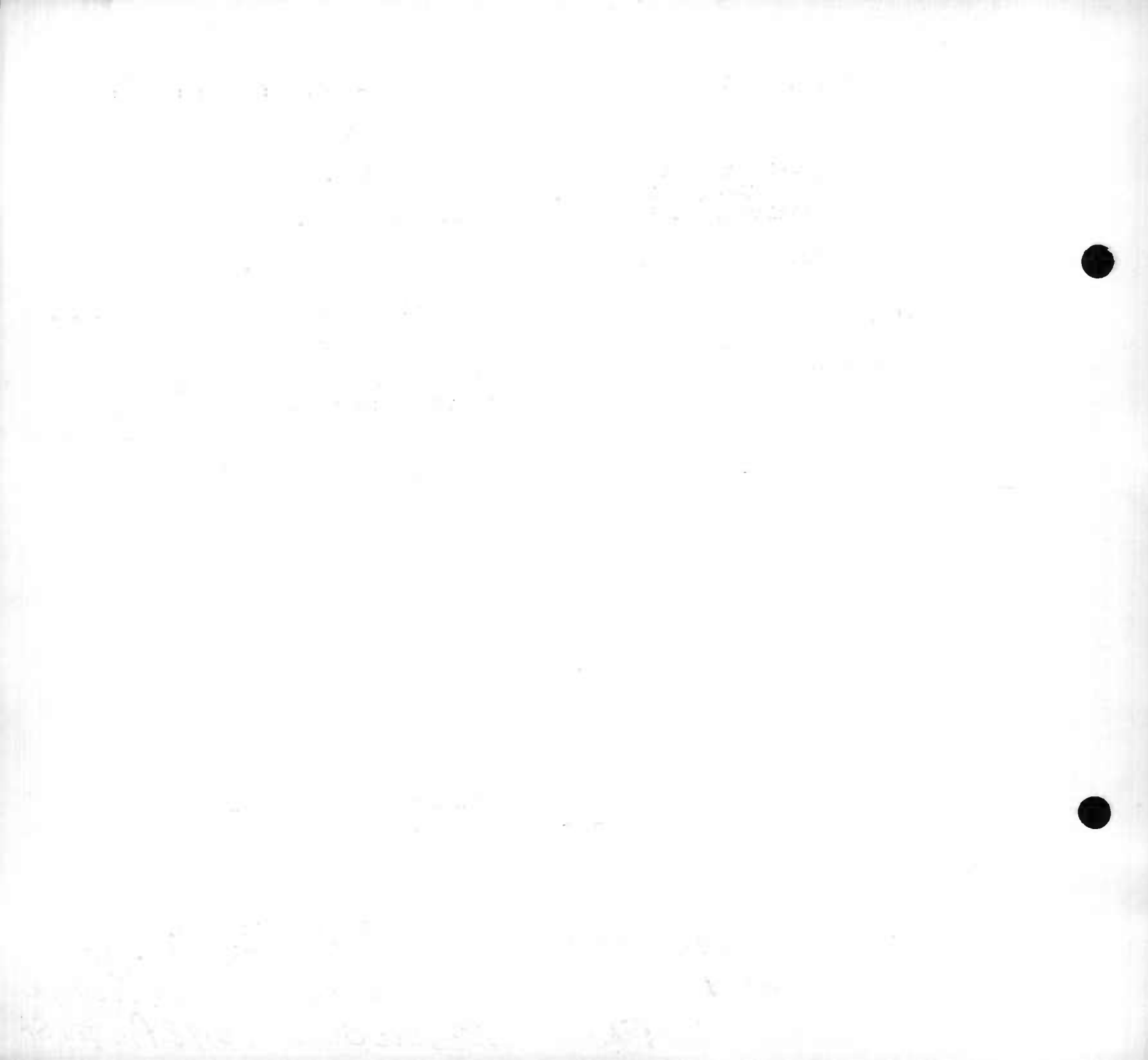
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 0534 | |
|--|------------------|---|---|---|---|---|---------------------------------------|
| BIRTH NO. 4-140 | | 71 0534 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HUBBELL, LEONARD ABRAHAM | | | | 2. DATE AND HOUR OF DEATH JANUARY 14, 1971 9:15 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MARYLAND | | B. COUNTY CHARLES COUNTY 5800 | |
| | | | | C. CITY OR TOWN WALDORF | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER RT 5 BOX 335H | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 09 11 16 | 9. AGE (in years last birthday) 54 | 10. UNDER 1 Yr. Months | 11. UNDER 24 Hrs. Days | 12. UNDER 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED | | | 10B. KIND OF BUSINESS OR INDUSTRY TIMBER LOGGING | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME HARRY H HUBBELL | | | | 14. MOTHER'S MAIDEN NAME KATIE (LANDIS) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-05-5896 | | 17. INFORMANT ST AGNES RECORDS-BALTO MD 21229 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 12/24/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor parietal @ 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 21 1970 to JANUARY 14 1971 that (X) (we) last saw the deceased alive on JANUARY 14 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. 23A. SIGNATURE Adolfo Alonso M.D. 23B. DATE SIGNED 01 14 71 23C. PHYSICIAN'S NAME (Type) ADOLFO ALONSO M.D. 23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE Jan. 18, 1971 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park 24D. LOCATION (City, town, or county) (State) Glen Burnie Md. 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR G. R. Small 25D. ADDRESS 1777 N. ... | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-652 71 0535 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0535 | |
|---|------------------|---|-------------------------------|---|---|--|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Prince, Mattie | | | | 2. DATE AND HOUR OF DEATH 1-16-71 8:45 A.M. 8:45 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Heights Ave. Baltimore, Md. 21215 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | | B. COUNTY | |
| C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 3908 Edgewood Rd. | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov 26-95 | 9. AGE (in years last birthday) 75 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? Yes U.S.A. | |
| 13. FATHER'S NAME Anthony Moore | | | | 14. MOTHER'S MAIDEN NAME Julia Frances | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Edith Mc Cormick (Daughter) | | ADDRESS Same same | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HCV D & Renal Failure Nephrosclerosis DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? weeks | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-9-70 to 1-16-71 that (I) (we) last saw the deceased alive on 1-16-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Elija Sanders | | | | 23B. DATE SIGNED 1/17/71 | | 23C. PHYSICIAN'S NAME (Type) E. J. F. H. SANDERS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Shipped | | 24B. DATE 1-19-70 | | 24C. NAME OF CEMETERY OR CREMATORY Sanford North Carolina | | 24D. LOCATION (City, town, or county) (State) 217 E Preston St | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR R. E. J. R. | | 25C. FUNERAL DIRECTOR Rayner Sanders | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--------------------------------------|--|---|
| L-000 71 0536 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0536 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) LEE, CECIL | | 2. DATE AND HOUR OF DEATH 1-15-71 4:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1512 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215 | | E. STREET AND NUMBER 2810 Ulman Avenue | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-8-1937 | 9. AGE (in years last birthday) 33 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store manager | | 10B. KIND OF BUSINESS OR INDUSTRY Md. Carpet Co. | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Ulysses O. Lee | | 14. MOTHER'S MAIDEN NAME Etta Treakle | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 231-44-4531 | | 17. INFORMANT ADDRESS Mrs. Elaine Lee 2810 Ulman Avenue | |
| 18. 430.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Massive subarachnoid hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intracerebral & rupture into ventricles (B) Edema Cerebral severe DUE TO, OR AS A CONSEQUENCE OF: Severe Pulm. Cong. Bilat. Acute Hepatic Cong. acute splenic Cong. (C) mdd. renal congestion | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/13/71 to 1/15/71 that (I) (we) last saw the deceased alive on 1/15/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Webster Sewell M.D. | | | | 23B. DATE SIGNED Jan. 18, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) WEBSTER SEWELL M.D. | | 23D. ADDRESS 2600 Liberty Heights Ave. Baltimore, Md.. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-20-1971 | | 24C. NAME of CEMETERY or CREMATORY Shiloh Baptist Cemetery | |
| 24D. LOCATION Reedville | | 24E. LOCATION Virginia | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 19 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR NUTTY FUNERAL HOME 3035 W. NORTH AVE. | |

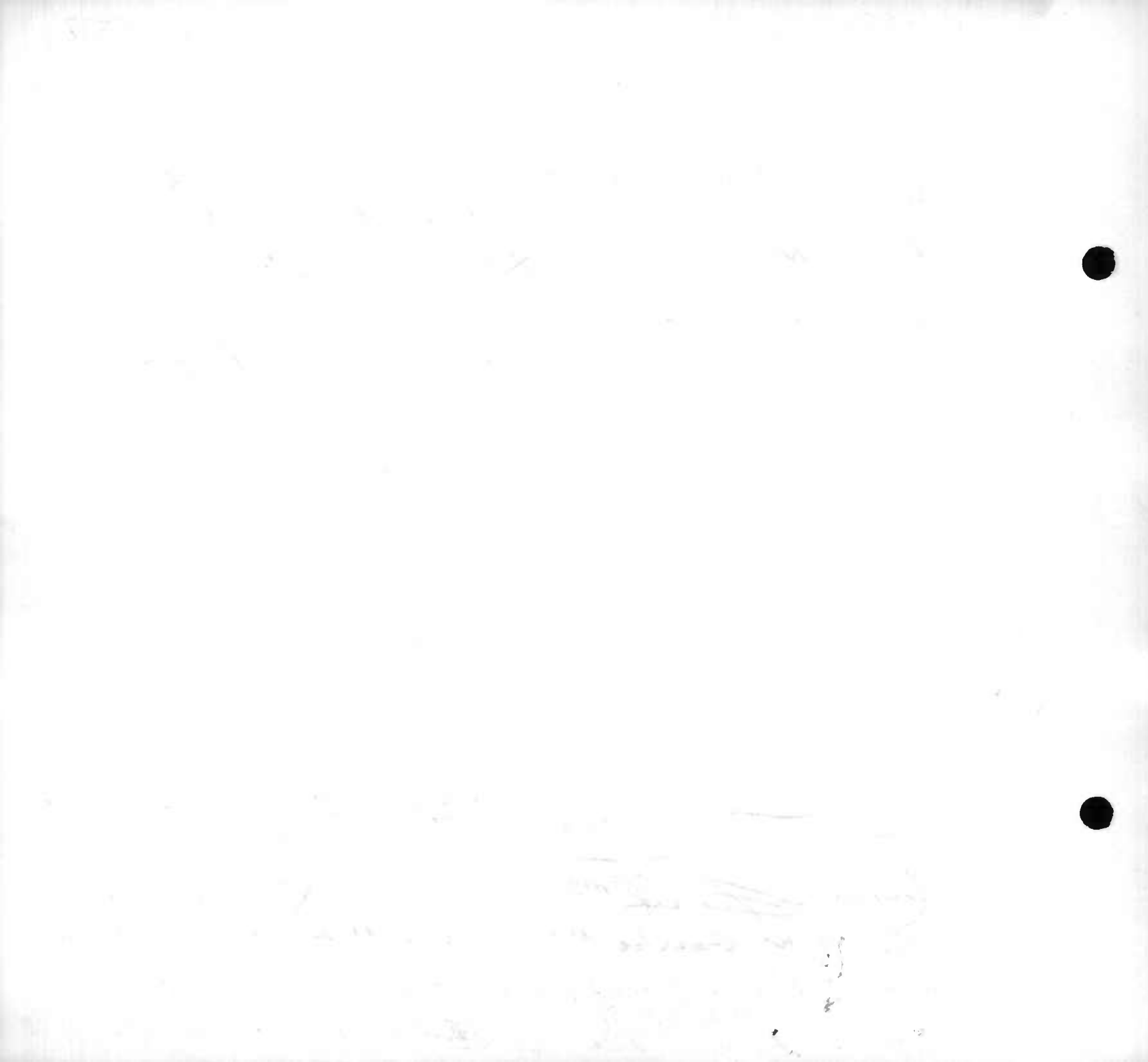
Mr. J. H. Brown & Co. 100
Chas. Street, N.Y.
Essex House, 100 N.Y.
and sent to the
N.Y. N.Y. N.Y.

Wm. J. Brown & Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0537 | |
|--|------------------|---|------------------------------------|---|--|
| G-650 71 0537 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Sindie Gorham</i> | | 2. DATE AND HOUR OF DEATH <i>1/16/71 11:55 PM</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>906</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> <i>44</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <i>1909 E. 32nd St</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>4/20/19</i> | 9. AGE (in years last birth) <i>52</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY | | | | | |
| 13. FATHER'S NAME <i>John Pope</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Brant HOPE</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>2509 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>DIABETES MELLITUS</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>many years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month (Day) (Year) (Hour) (APPROX.)) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/14/71</i> 19 <i>71</i> to <i>1/16/71</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>1/16/71</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Ronald W. Geckler M.D.</i> DEGREE | | 23B. DATE SIGNED <i>1/16/71</i> | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS <i>Union Memorial Hosp. Baltimore, MD</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | | 24B. DATE <i>1/18/71</i> | | 24C. NAME of CEMETERY or CREMATORY <i>CEDARVIEW CEM</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>ENfield. N.C.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1971</i> | | 25B. NAME OF REGISTRAR <i>Blue E. ...</i> | | 25C. FUNERAL DIRECTOR <i>... ENfield N.C.</i> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. *D-540*
69-13971

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) DONNA L. DANIEL | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 16 Year 71 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 4509 Fairview Ave. | | 3. DATE PRONOUNCED DEAD Month 1 Day 16 Year 1971 Hour 4:17 p.m. | |
| 6. SEX female | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8/2/69 | | 10. AGE (In years lost birthday) 17 mo. | |
| 11. BIRTHPLACE (State or foreign country) BALTO. Md | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Florence Wilkinson | | ADDRESS 2706 Montebello | |
| 19. E91071 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Drowning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4509 Fairview Ave. 2843 | | 22F. HOW DID INJURY OCCUR? Drowned in bathtub. | |
| 22D. TIME OF INJURY (APPROX.) 1-16-71 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. DATE SIGNED 1-17-71 EXAMINER'S NAME (Type) | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/20/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary | | 24D. LOCATION (City, town, or county) (State) A.A. County, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | 25B. NAME OF REGISTRAR Isidore Mihalakis, M.D. | |
| 25C. FUNERAL DIRECTOR Joseph L. Locks | | ADDRESS 1304 N. Central Ave. | |

31 0535

31 0535

VALLEY ROAD CO

R. S. HANBURY

VALLEY ROAD CO

H-426

71

0539

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0539

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MERILYN M. HOLCHER

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1703 E. 31st St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒X NO ☐

6. SEX

Female

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

26 Dec 1909

10. AGE (In years
last birthday)

61

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1703 E. 31st St.

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RICHARD C. ACHBORN

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

HELEN A. JACKSON

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

MRS. BETTY JIMSON, OCEAN CITY, MD.

19.

E950.0

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Barbiturate overdose
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1703 E. 31st Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

1-14-71

?

m.

22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Ingested overdose of barbiturates

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-16-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial/Removal

24B. DATE

19 JAN 71

24C. NAME OF CEMETERY or CREMATORY

MOUNTAIN VIEW CEM.

24D. LOCATION (City, town, or county)

MOUNTAIN CITY, TENN.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1971

25B. NAME OF REGISTRAR

JAN 20 1971

25C. FUNERAL DIRECTOR

CHERRY FUNERAL HOME

ADDRESS

MT. CITY, TENN.

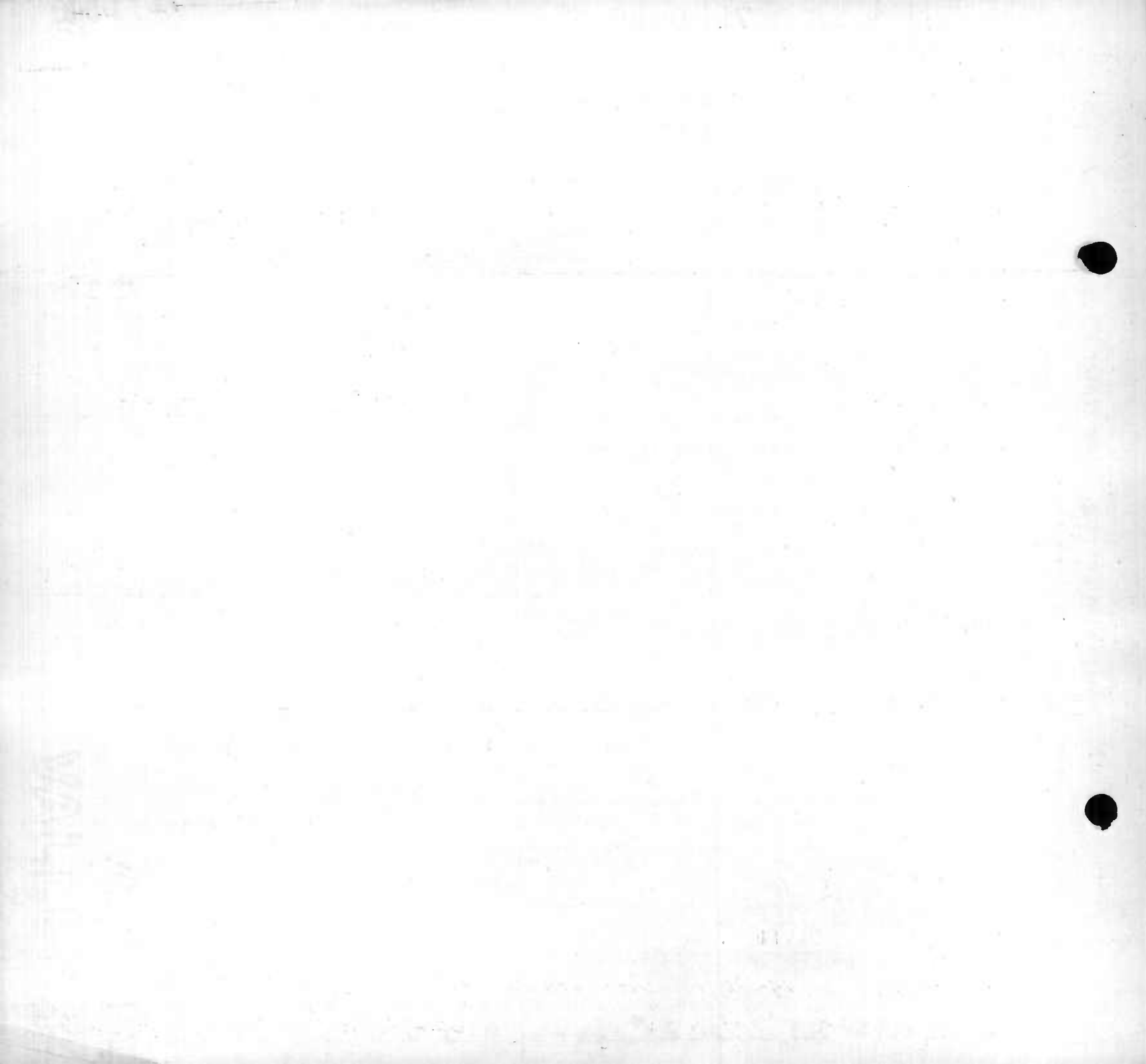
Letter from M.C.'s office
1-79-71 M.H.

ACADEMY-BOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | |
|--|-------------------------|---|-----------------------------------|---|
| BIRTH NO. <u>P-362</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71 0540</u> |
| 1. NAME OF DECEASED (Type or Print) <u>MARY PETERSON</u> | | 2. DATE AND HOUR OF DEATH <u>Jan. 16, 1971</u> <u>3:15</u> PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>DUNDALK</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>228 BALTIMORE AVENUE</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-2-93</u> | 9. AGE (In years lost birthday) <u>77</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>N.D.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>SAMUEL BOOZ JOHN RODEN</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>ANNA BOOZE</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>W. H. PETERSON, 234 BALTO. AVE.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>5-75-X</u> CAUSE OF DEATH <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) <u>? PULMONARY EMBOLUS</u> (C) <u>BEDREST FOR CHOLECYSTITIS</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>0</u> <u>3 MIN</u> <u>7 DAYS</u> | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>David R. Albritton</u> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <u>DAVID R. ALBRITTON</u> |
| 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | |
| 24B. DATE <u>19 JAN 71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN CEM.</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. F. [illegible]</u> | | 25C. FUNERAL DIRECTOR <u>Glenn [illegible] FUNERAL HOME, DUNDALK</u> |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|-------------------------|---|---|--|--|--|--|-------------------------|--|
| BIRTH NO. <u>M-460</u> | | 71 0541 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. <u>71 0541</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>MILLER, ANNA LAURA</u> | | | | 2. DATE AND HOUR OF DEATH <u>JANUARY 16 1971</u> <u>10</u> P. M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>HOWARD COUNTY</u> C. CITY OR TOWN <u>ELLICOTT CITY</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3411 DOGWOOD DRIVE</u> | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2 28 98</u> | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>236 82 9344</u> | | 17. INFORMANT ADDRESS <u>Mrs. Leoda Deutsch, 3411 Dogwood Drive</u> <u>ST AGNES HOSPITAL MEDICAL RECORDS</u> | | | | |
| 18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>Cerebro Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>JANUARY 16</u> 19 <u>71</u> to <u>JANUARY 16</u> 19 <u>71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>JANUARY 16</u> 19 <u>71</u> and that in <u>(XX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Horacio Guzman</u> | | | | DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/16/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>HORACIA GUZMAN</u> | | | | 23D. ADDRESS <u>21229 ST. AGNES HOSPITAL BALTIMORE, MARYLAND</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-20-1971</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Paul Lutheran Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Shenandoah Co., Jerome, Virginia</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Hubbert</u> | | 25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> | | ADDRESS <u>4107 Wilkens Ave, 21229</u> | | | |

1. The first part of the paper is devoted to a discussion of the

main results of the paper.

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main results of the paper.

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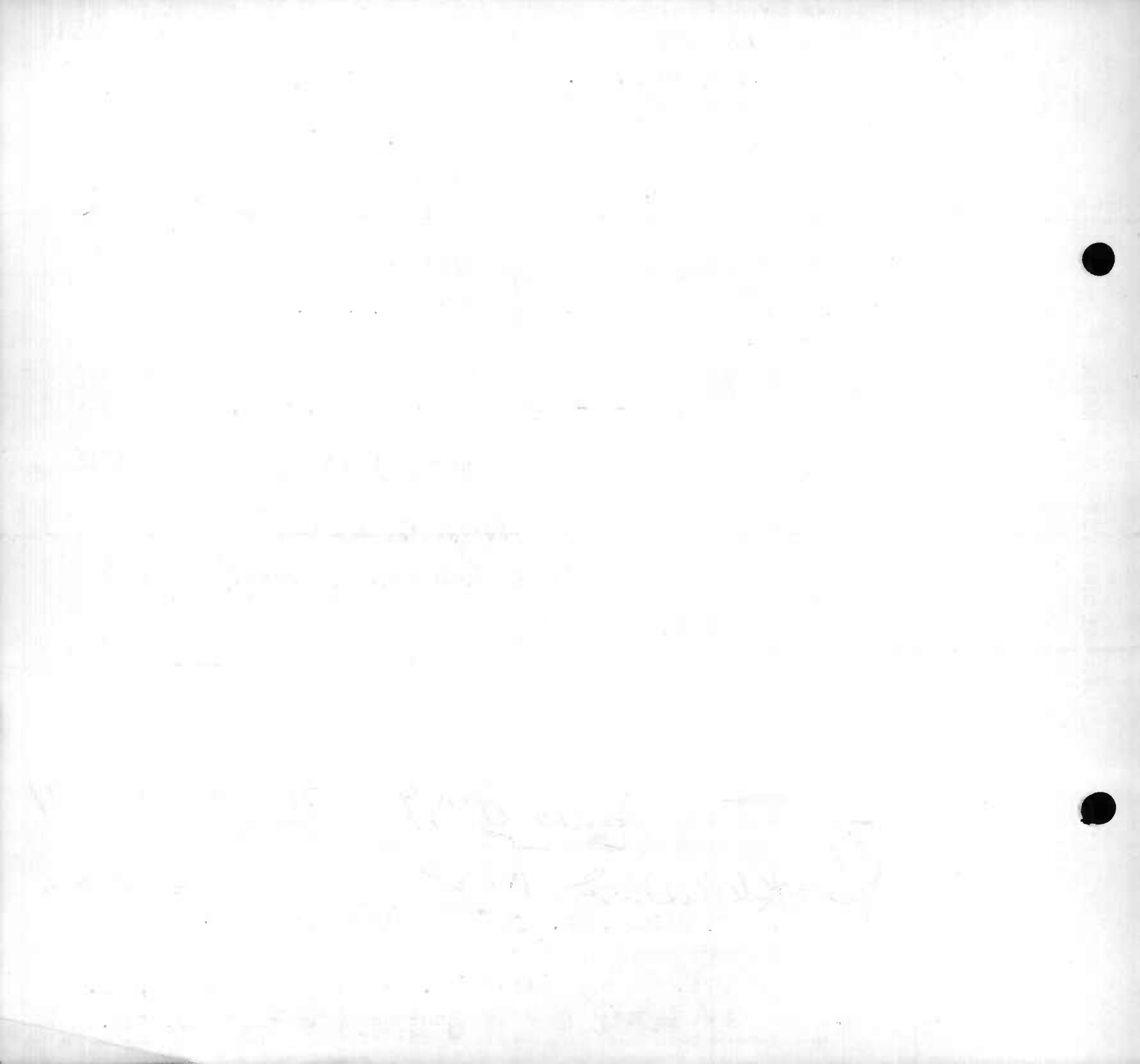
The fifth part of the paper is devoted to a discussion of the

main results of the paper.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

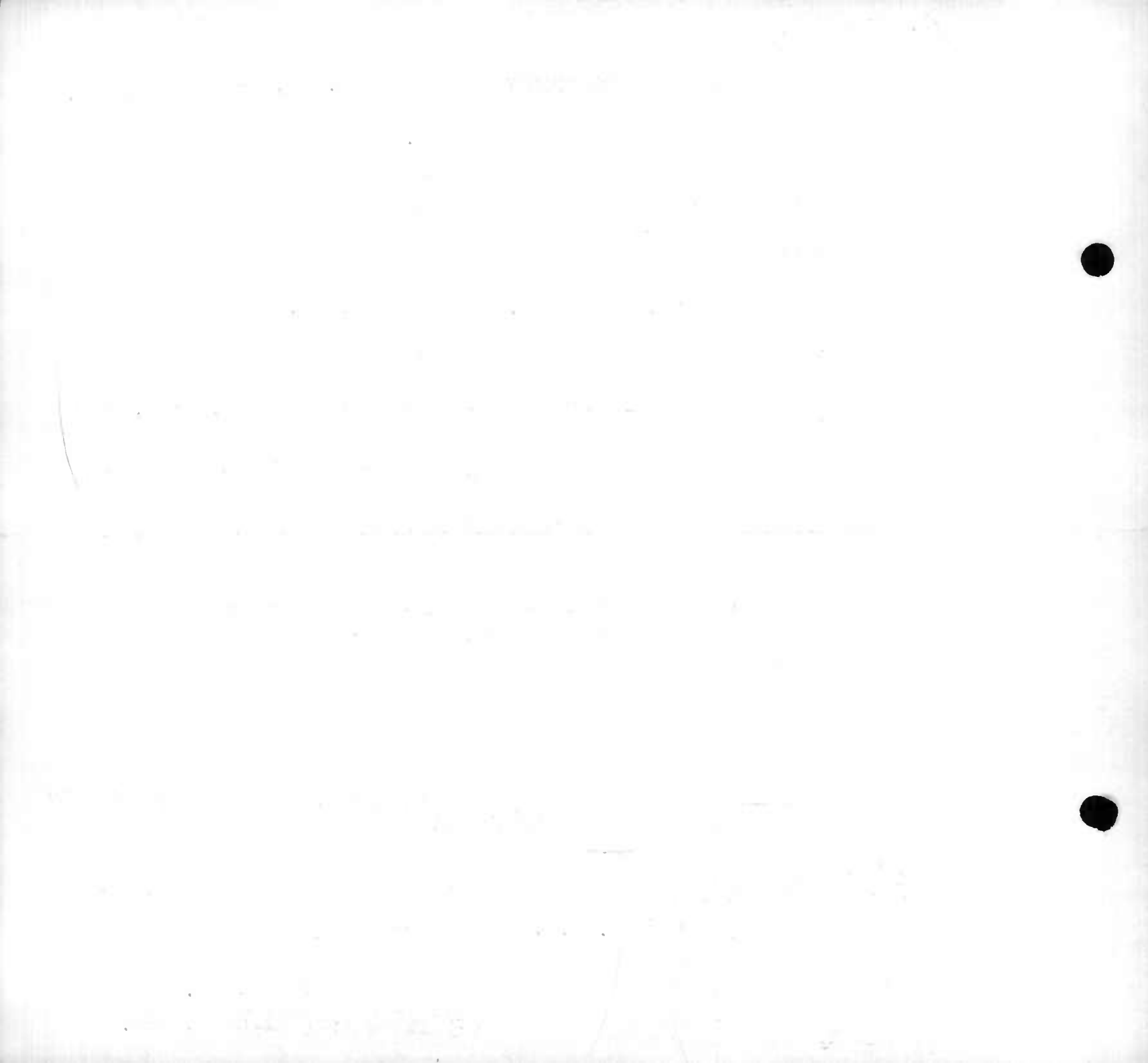
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 71 0542 |
|--|--|--|--|---|---------|
| S-500 71 0542 CERTIFICATE OF DEATH | | BIRTH NO. 1. NAME OF DECEASED (Type or Print) HARRY SIMA, SR. | | | |
| 2. DATE AND HOUR OF DEATH 1/14/71 7 a. M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21206 B. COUNTY 2642 | | | |
| 5. SEX male | | 6. RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8/11/87 | | 9. AGE (In years lost birthday) 83 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Emil Sima | | 14. MOTHER'S MAIDEN NAME Mary Ruzicka | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-07-4963 | | 17. INFORMANT Anna Eff Sima, wife, a bove | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 43801 | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hemi-plegia (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) Arteriosclerosis Generalized | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 9 19 71 to Jan 14 19 71, that (I) (we) lost saw the deceased alive on Jan 13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louis F. Klimes, MD. | | | | 23B. DATE SIGNED Jan 15, 19 71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/16/71 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gardens | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | | |
| 25D. ADDRESS 3331 Brehms Lane | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

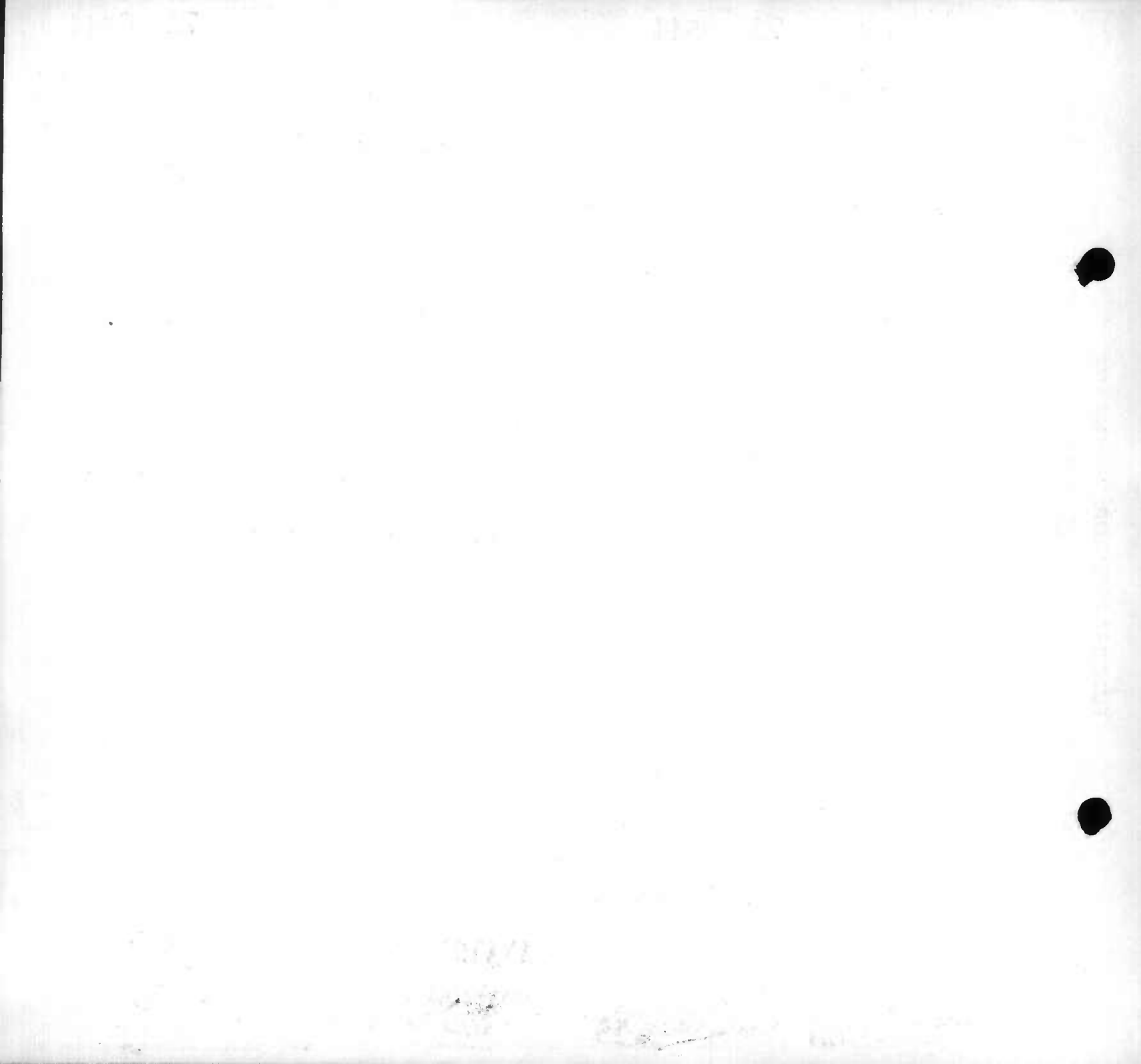
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0543</u> | |
|---|----------------------|---|--|--|--|
| BIRTH NO. <u>D-515</u> | | 71 0543 | | | |
| 1. NAME OF DECEASED (Type or Print) JOSEPH FRANK DEMBNY | | | 2. DATE AND HOUR OF DEATH Jan. 14, 1971 <u>4:45 P.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Gould Nursing Home</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21213 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3439 Parklawn Avenue | | |
| 5. SEX male | 6. RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/22/92 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY National Can Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME unknown | | | 14. MOTHER'S MAIDEN NAME unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-09-2033 | | 17. INFORMANT Helen Kapralek Dembny, wife, above | |
| 18. <u>4331</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cerebrovascular Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Emphysema, Heart Failure, & Arthritis Previous Cerebral Thrombosis, Death | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/12/1970</u> to <u>1/14/1971</u> that (I) (we) last saw the deceased alive on <u>1/13/1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Albert B. Bradley</u> | | | 23B. DATE SIGNED <u>1/16/71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) Bradley, Albert B. M.D. | | | 23D. ADDRESS 4900 Belair Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/18/71 | | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | 25B. NAME OF REGISTRAR 26. E. J. B. M.D. | | 25C. FUNERAL DIRECTOR Schimmek Funeral Home, Inc. | |
| | | | | ADDRESS 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|-------------------------------------|---|---|
| B-620 71 0544 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0544 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Burke, Louise</u> | | 2. DATE AND HOUR OF DEATH <u>1/13/71</u> @ <u>9¹⁰ AM</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2710</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> | | (If not in hospital or institution, give street address or location) | | E. STREET AND NUMBER | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>02/1/197</u> | 9. AGE (In years last birthday) <u>73</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>470.01</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Poss. Coronary occlusion</u> | | <u>Unknown</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>January 1970</u> to <u>January 12 1971</u> | | that (I) (we) last saw the deceased alive on <u>Jan. 12 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <u>W. Alexander, M.D.</u> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | 23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 23F. ANATOMY BOARD OF MARYLAND | |
| 23G. UNIVERSITY MEDICAL SCHOOL | | 23H. MORTUARY SERVICE - BCHD | | 23I. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1-14-71</u> | | 24C. NAME OF CEMETERY or CREMATOR | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | 24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | |
| 24G. FUNERAL DIRECTOR | | 24H. ADDRESS | | 24I. VS 150-REV. 1/1/68 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0545 4 | |
|--|--|--|--|---|--|
| C-620 BIRTH NO. 71-00071 0545 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Crews | | | | 2. DATE AND HOUR OF DEATH 1-5-71 6⁰⁰ P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD South Baltimore General Hospital 43 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2552 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital 43 | | | | C. CITY OR TOWN Balt D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 1-5-71 9. AGE (in years last birthday) 2 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY | |
| 13. FATHER'S NAME Joseph JR | | | | 14. MOTHER'S MAIDEN NAME Johnson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT CHART | | | | ADDRESS | |
| 18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Prematurity | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/5 19 71 to 1/5 19 71 that (I) (we) last saw the deceased alive on 1/5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James A. Kopper M.D. | | | | 23B. DATE SIGNED 1/5/71 | |
| 23C. PHYSICIAN'S NAME (Type) James A. Kopper M.D. | | | | 23D. ADDRESS S. B. G. H. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Disposition | | 24B. DATE 1-18-71 | | 24C. NAME OF CEMETERY OR CREMATION ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | 25B. NAME OF REGISTRAR Robert E. Kelly | | 25C. ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |

Joseph Jr

1824

W

Chart

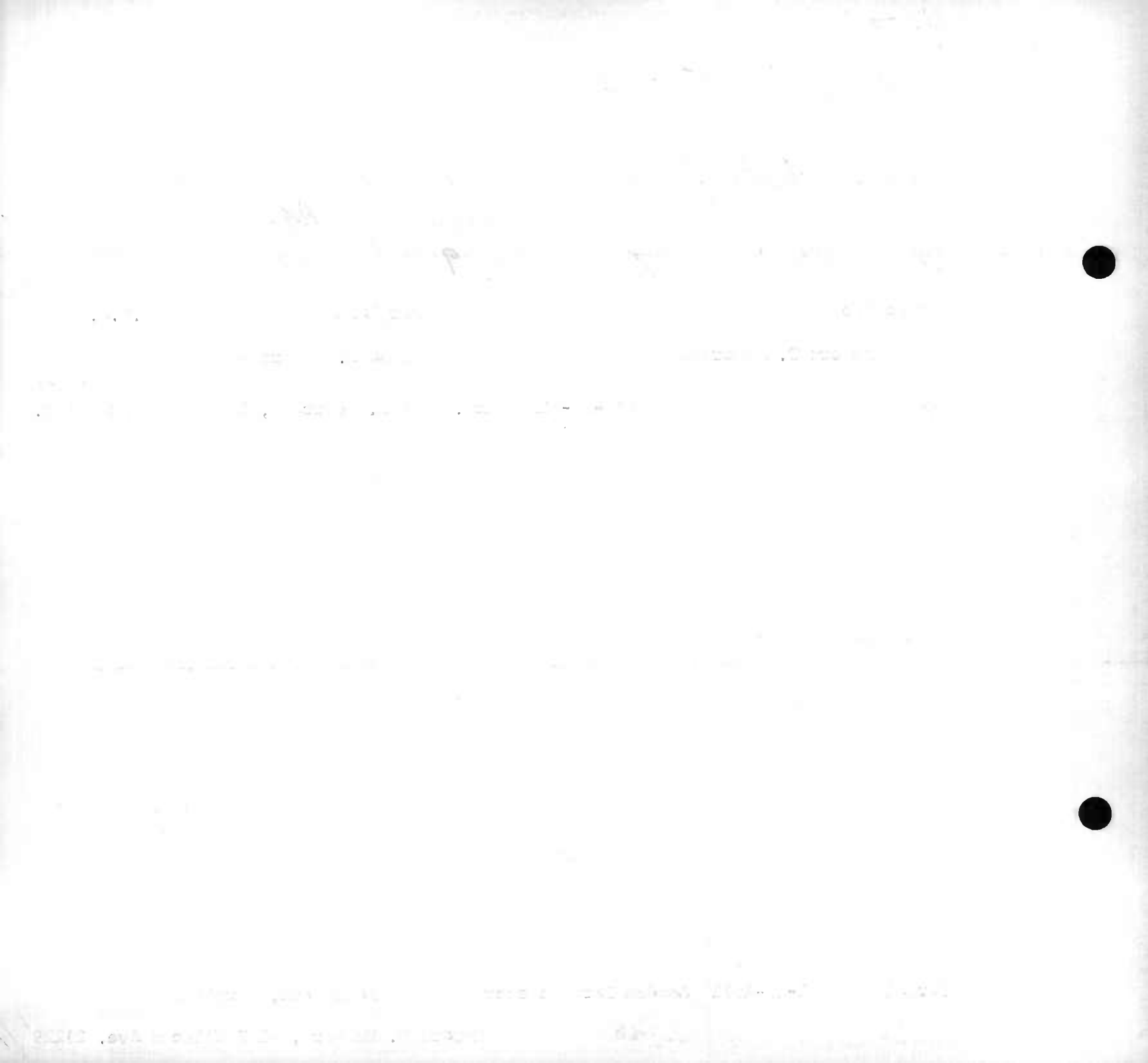
Joseph Jr

JOSEPH JR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

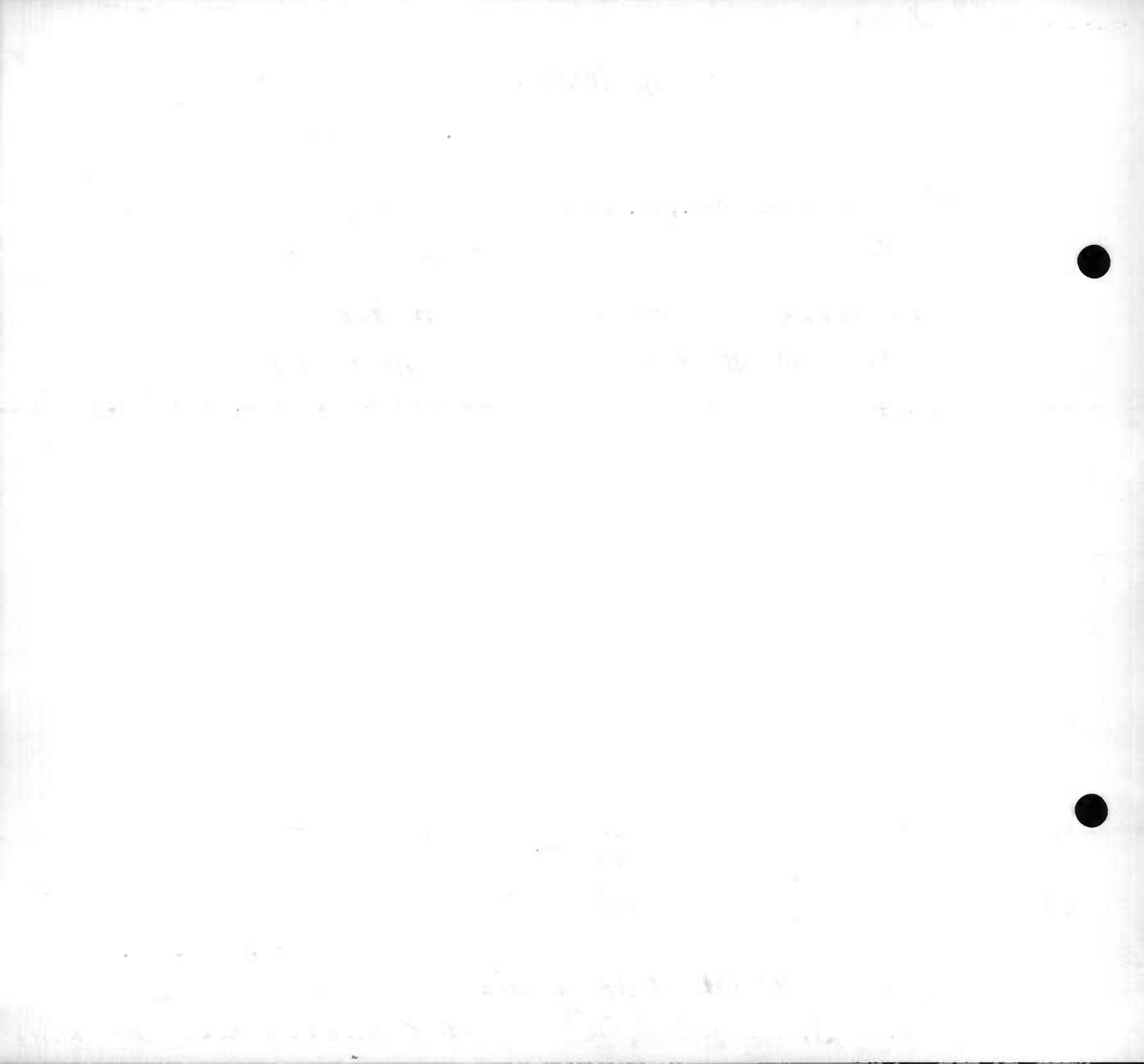
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0546</u> | |
|--|--------------------|--|---|---|--|
| BIRTH NO. <u>A-536</u> | | 71 0546 | | DATE AND HOUR OF DEATH <u>1/16/71 1:20 P.M.</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>ANDERSON, THERESA</u> | | | 2. DATE AND HOUR OF DEATH | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN Hospital of MD.</u> | | | A. STATE <u>MD.</u> | | |
| 46 | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>1009 Wilmington Ave.</u> | | |
| 5. SEX <u>FE</u> | 6. RACE <u>wh.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/29/86</u> | 9. AGE (in years last birthday) <u>34</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Robert T. Anderson</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna E. Anderson</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-54-0151</u> | | 17. INFORMANT ADDRESS <u>21223 Mrs. Anna E. McCreedy, 1009 Wilmington Ave.</u> | |
| 18. <u>450X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EMBOLISM AND PNEUMONIA</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 19A. DATE OF OPERATION <u>0 -</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>T</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>-</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/11/71</u> 19 <u>71</u> to <u>1/16/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/16/71</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>S. BASU</u> | | | | 23B. DATE SIGNED <u>1/16/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u> | | | | 23D. ADDRESS <u>Lutheran Hospital of Maryland</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-19-1971</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Hubbard</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| H-200 | | 71 0547 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0547 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | REG. NO. | |
| | | HOWARD H. HICKS | | January 16 1971 7:53 a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Balto., Md. 21224 | | | | Md. Baltimore | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Male | | | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| ENGINEER | | | | SOAP | | 1-14-10 | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| ROBERT H. HICKS | | | | ROSE PAULEY | | 61 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) | |
| UNK | | | | | | W. VA. | |
| 17. INFORMANT | | | | ADDRESS | | 12. CITIZEN OF WHAT COUNTRY? | |
| BCH Records: 4940 Eastern Avenue | | | | Baltimore, Maryland 21224 | | USA | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | ACUTE MYOCARDIAL INFARCTION | | 2 Hours | |
| ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | ATHEROSCLEROTIC CARDIOVASCULAR | | YEARS. | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | DIABETES MELLITUS | | 10 YEARS | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 16th 1971 to January 16th 1971 that (I) (we) lost saw the deceased alive on January 16th 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| James R. Young M.D. | | | | Jan 16 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| JAMES R. H. YOUNG | | | | BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Balto., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 1/20/71 | | OAK LAWN | | BALTO. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 20 1971 | | R. E. Fisher, M.D. | | J. B. CORRELL & SONS | | 300 MAICE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | |
|--|----------------------|--|---|---|---|--|--|--|--|
| BIRTH NO. 71 0548 | | REG. NO. 71 0548 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Eleanor A. Swingle</u> | | | | 2. DATE AND HOUR OF DEATH <u>1-18-71</u> <u>1:30 P.M.</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>AA CO.</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u> | | | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER <u>116 Franklin Ave</u> | | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-10-10</u> | 9. AGE (in years last birthday) <u>60</u> | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pai</u> | | | | | |
| 13. FATHER'S NAME <u>Richardson</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Keech - Lutheran Hosp.</u> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRO-VASCULAR ACCIDENT</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CARCINOMA LT. BREAST</u> | | | DUE TO, OR AS A CONSEQUENCE OF: <u>1 yr.</u> | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Metastatic lesion bones.</u> | | | DUE TO, OR AS A CONSEQUENCE OF: <u>18d.</u> | | | | | | |
| 19A. DATE OF OPERATION <u>1/11/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fracture Hip.</u> | | 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>116 Franklin Ave</u> | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>DEC 31 1970</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>FELL AT HOME</u> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> 19 <u>70</u> to <u>1/18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Samart Veohongsant M.D.</u> | | | | 23B. DATE SIGNED <u>1/18/71</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>SAMART VEOHONGSANT</u> | | | | 23D. ADDRESS <u>Lutheran Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-21-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Kizer Cemetery</u> | | | | | |
| 24D. LOCATION (City, town, or county) <u>Cortez, Pa.</u> | | 24E. LOCATION (City, town, or county) <u>Pai</u> | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Sauer</u> | | 25C. FUNERAL DIRECTOR <u>W. E. Cully</u> | | | | | |

called hospital 0.00. 21225

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0549 | |
|--|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. <u>71-2337671</u> | | 0549 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>VASALLO, JUAN CARLOS</u> | | 2. DATE AND HOUR OF DEATH <u>1/16/71</u> | | <u>9:40A</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE <u>MARYLAND</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST AGNES HOSPITAL</u> | | B. COUNTY | | C. CITY OR TOWN <u>BALTIMORE</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER <u>4938 LINSAY RD</u> | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/18/70</u> | 9. AGE (In years last birthday) <u>19</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>PAULINO VASALLO</u> | | 14. MOTHER'S MAIDEN NAME <u>LUCIA PEREZ</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>CATON BALTO MD ADDRESS 29 ST AGNES HOSPITAL RECORDS WILKINS &</u> | |
| 18. <u>02991</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration ?</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>vine infection ?</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 - 24 hours</u> <u>7 days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>1/15/71</u> to <u>1/16/71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>1/16/71</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Yupadee</u> | | DEGREE <u>YUPADEE</u> | | 23B. DATE SIGNED <u>1.16.70</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <u>St Agnes</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1/18/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>GARDEN OF HAVEN</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>SILVER SPRING MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR <u>AD-3149 NABE</u> | | ADDRESS <u>301 Frederick Rd. Catonsville, Md. 21228</u> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | |
|---|---------------------|---|---|--|---|---|---|--|--------------------------------------|---|--|
| T-650 | | 71 0530 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 71 0530 | | | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>ETHNA Belle Thorne</i> | | | | | 2. DATE AND HOUR OF DEATH <i>1-16-71 7:15 pm</i> | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Hartford Gardens Nursing Home</i> | | | | | A. STATE <i>MARYLAND</i> | | B. COUNTY <i>Balto.</i> | | C. CITY OR TOWN <i>Baltimore</i> | | |
| | | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| | | | | | E. STREET AND NUMBER <i>2023 Russell Ave #21207</i> | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-10-72</i> | 9. AGE (In years last birthday) <i>98</i> | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self-Employed</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <i>ILLINOIS</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Joseph Callen</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Hoskins</i> | | | | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <i>218-46-1838</i> | | 17. INFORMANT <i>Mabel I Ruckart - Same</i> | | | ADDRESS | |
| 18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | CAUSE OF DEATH <i>Anterior chronic C. V. disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>December 15</i> 19 <i>70</i> to <i>January 16</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>January 13</i> 19 <i>71</i> and that (in my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>C. Allan Spier</i> | | | | | DEGREE <i>Attending Phys.</i> <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>1/18/71</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | | 24B. DATE <i>1-20-71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Lawson Park Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State) <i>BALTO, MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1971</i> | | | 25B. NAME OF REGISTRAR <i>Charles E. [Signature]</i> | | | 25C. FUNERAL DIRECTOR <i>Armacost Funeral Chapel</i> | | | ADDRESS <i>4600 Liberty Hgts.</i> | | |

Box 100-11, London Park (Monty) Bldg. Md

24-4-48 Monty I. Dickert-Jame
Hoskins

Joseph Galley
Self Employed

Illinois
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F W X

Harford Gardens Washington 2033 Russell Ave #2102
Baltimore
Baltimore

A-636

71

0551

BALTIMORE CITY HEALTH DEPARTMENT

71

0551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

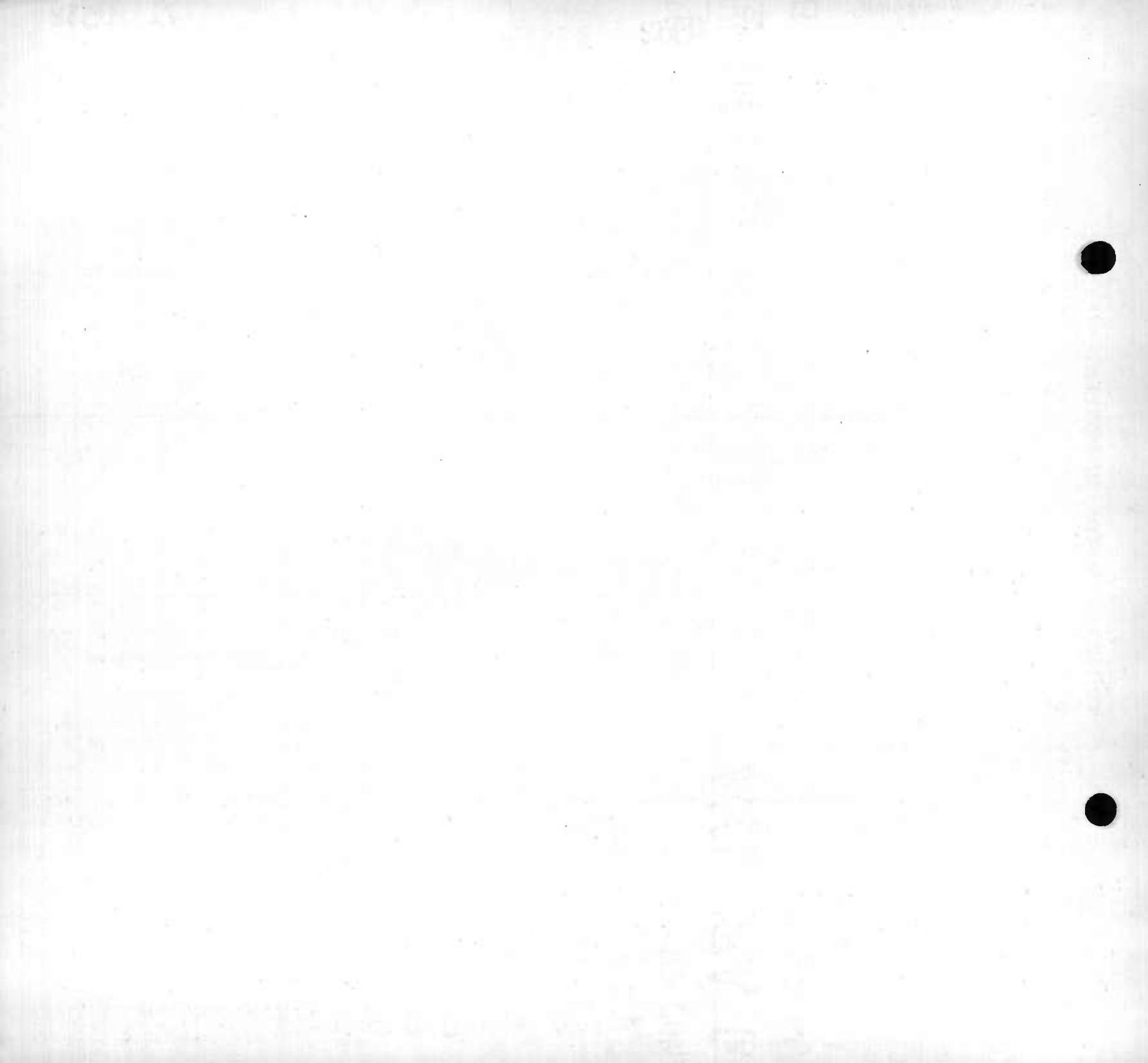
BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Shirley Arthur | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 17 71 10:40a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 71 10:40am. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore | |
| 9. DATE OF BIRTH July 2, 1940 | | 10. AGE (In years lost birthday) 30 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Key punch Operator | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 214-38-6639 | |
| 18. INFORMANT Margaret Chire | | ADDRESS 5332 Maple Avenue 21215 | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 577.01 | | CAUSE OF DEATH Acute necrotizing pancreatitis with generalized peritonitis | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2-2-71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 1/18/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-17-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | 25B. NAME OF REGISTRAR Robert E. [illegible] | |
| 25C. FUNERAL DIRECTOR Arnacost Funeral Chapel | | ADDRESS 4600 Liberty Hts | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 71 0552 |
|---|--------------------------------|--|--|--|--|
| BIRTH NO. <div style="font-size: 2em; font-weight: bold;">C-236</div> | | <div style="font-size: 2em; font-weight: bold;">71 0552</div> | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>DOROTHY L. COSTER</u> | | | 2. DATE AND HOUR OF DEATH <u>1/14/71</u> <u>7:30</u> P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>4620 Monrovia Rd</u> <u>Baltimore, Maryland 21229</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2864</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4620 MANOR DENE RD</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-16-1891</u> | 9. AGE (In years last birthday) <u>79</u> If Under 1 Yr. Months: Days: Hours: Min. | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
| 13. FATHER'S NAME <u>J. Newton Gregg</u> | | | 14. MOTHER'S MAIDEN NAME <u>Cecelia Richardson</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>216-46-3173</u> | | 17. INFORMANT <u>Mr. B. Gregg Coster, 3350 Coventry Rd. Mo</u> ADDRESS <u>ELICOTT CITY</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coron Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) Atherosclerosis Coron Artery Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension <u>Chronic</u> <u>Diabetes Mellitus</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 yrs</u> <u>Not Known</u> | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/8/67</u> 19 <u>70</u> to <u>1/14</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>5/6/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Cliff Ratliff, Jr.</u> | | | | 23B. DATE SIGNED <u>1/15/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR</u> | | | | 23D. ADDRESS <u>4605 EDMONDSON AVE</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-18-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>LOLIDON PARK CEMETERY</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>3801 FREDRICK RD, BALT. MO.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Howard County</u> | | 25C. FUNERAL DIRECTOR <u>ELICOTT CITY MD</u> ADDRESS <u>HOWARD COUNTY FUNERAL HOME OF H.H. WITZKE</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0553 | |
|---|---|--|--|---|---|
| H-430 71 0553 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. H-430 | | 1. NAME OF DECEASED (Type or Print) HOLLIDAY MR. ROBERT | | | |
| 2. DATE AND HOUR OF DEATH January, 19, 1971 | | 2:35 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 34 Bon Secours Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1903 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 122 S. GILMOR STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 11, 1909 | 9. AGE (in years last birthday) 61 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired helper | | 10B. KIND OF BUSINESS OR INDUSTRY Express Co. | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William Holliday | | | |
| 14. MOTHER'S MAIDEN NAME Smith | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 214-18-1954 | | | |
| 16. SOCIAL SECURITY NO. 214-18-1954 | | 17. INFORMANT Catherine F. Holliday ADDRESS HOSPITAL CHART 122 S Gilmor St. | | | |
| 18. 6-19-71 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Respiratory failure. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days. | |
| | | (B) Chronic obstructive Pulmonary disease DUE TO, OR AS A CONSEQUENCE OF: | | 8 years. | |
| | | (C) Cor Pulmonale | | 2 years. | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner —) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour () — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from January 6, 1971 to January 19, 1971 that (I) (we) last saw the deceased alive on January 19, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Chumsak Pruksapong M.D. | | 23B. DATE SIGNED January, 19, 1971 | | 23C. PHYSICIAN'S NAME (Type) CHUMSAK PRUKSA PONG M.D. | |
| 23D. ADDRESS Bon Secours Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71 | | 24C. NAME OF CEMETERY or CREMATORY Crestlawn | |
| 24D. LOCATION (City, town, or county) (State) Marriottsville Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | 25B. NAME OF REGISTRAR Robert J. Fisher, Jr. | | 25C. FUNERAL DIRECTOR W. J. S. Funeral Directors | |
| ADDRESS 4101 Edmondson Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|---|---|------------------------------------|--|--|---|--|---------------------------------------|--|
| 71 0554 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0554 | | | | | |
| 1. NAME OF DECEASED Type or Print DARDEN, CHERRY A | | | | | 2. DATE AND HOUR OF DEATH 1-19-71 12:20 AM | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSP. OF BALTIMORE INC. | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2717 | | | | | |
| | | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | E. STREET AND NUMBER 5302 MAPLE AVE. #15 | | | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-24-28 | | 9. AGE (In years lost birthday) 42 | | 10. If Under 1 Yr. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| 18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain, liver + Bone Metastases CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Breast (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 1-11-71 19 to 1-19-71 19 that (X) (we) last saw the deceased alive on 1-19-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE D. Emilio Suzara M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> President U.D. | | 23B. DATE SIGNED 1-19-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. EMILIO SUZARA | | | | | 23D. ADDRESS Sinai Hosp. Baltimore | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-22-71 | | 24C. NAME of CEMETERY or CREMATORY Ind-Calum | | 24D. LOCATION (City, town, or county) (State) Baltimore | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, MD. | | | 25C. FUNERAL DIRECTOR COOPER | | | ADDRESS 2700 Calverton Ave. | |

28 29

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0555 |
|---|---|---|--|---|
| BIRTH NO. D-145 | | 71 0555 | | |
| 1. NAME OF DECEASED (Type or Print) William Lawrence Devlin Sr. | | 2. DATE AND HOUR OF DEATH 1/18/71 10:55 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland 8. COUNTY 105 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Gould Convalesarium | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 325 S. Madeira Street #21231 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/10/97 | 9. AGE (In years last birthday) 73 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Gunther Brewery | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME James Devlin | | |
| 14. MOTHER'S MAIDEN NAME Mary Farley | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I | | |
| 16. SOCIAL SECURITY NO. 216-01-1907 | | 17. INFORMANT Catherine Krawczyk - 3489 Dunhaven Rd. | | |
| 18. 309.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dehydration / Cachexia | | |
| | | (B) Chronic Brain Syndrome | | |
| | | (C) Chronic Brain Syndrome | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Recurrent Urinary Tract Infection. Multiple Decubiti. Pulmonary Stasis. Peripheral Vascular Constriction. | | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/6/70 to 1/18/71 , that (I) (we) last saw the deceased alive on 1/12/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Albert B. Bradley | | 23B. DATE SIGNED 1/18/71 | | 23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY |
| 23D. ADDRESS 4900 BELAIR ROAD #21206 | | 24. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/21/71 | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | 25B. NAME OF REGISTRAR Robert E. Taylor | 25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231 | | |

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Mr. D. B. Bury

Mr. D. B. Bury

17th

71 0556

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0556

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM BONNER

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION

Baltimore City Hospitals

3. DATE PRONOUNCED DEAD Month Day Year Hour
1 16 1971 5:22 P.M.5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Tennessee B. COUNTY V-39

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Nashville

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

9/26/27

10. AGE (In years last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1215 8th St.

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Collie Bonner

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Bessie Gaston Bailey

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mason Funeral Home, Ala

19. 412.4 I

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-17-71

24A. BURIAL CREMATION, REMOVAL (Type)

24B. DATE

1/25/71

24C. NAME OF CEMETERY or CREMATORY

Little Elk Cemetery

24D. LOCATION (City, town, or county) (State)

Athens Ala

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 20 1971

Robert E. Taylor, M.D.

Halstead 1206 W

north Ave

ACADEMY

VALLEY

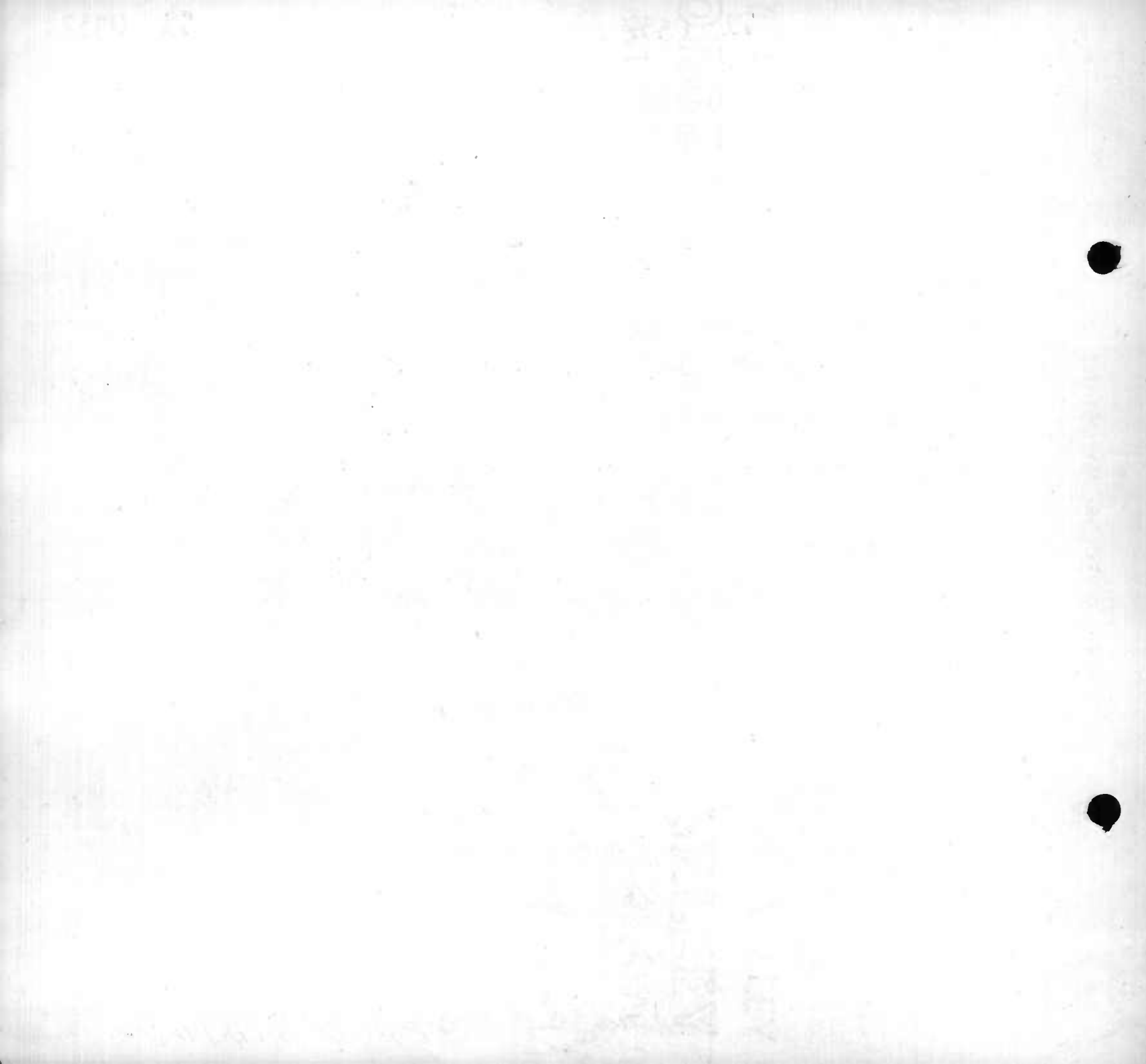
U.S.A.

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|--|------------------------------------|---|---|
| B-652 71 0557 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0587 | |
| 1. NAME OF DECEASED (Type or Print) <i>Jessie Barnes</i> | | 2. DATE AND HOUR OF DEATH <i>Jan 18, 1971 7:15 PM</i> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>908</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Pleasant Manor Nursing Home</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <i>1903 Steward Ave.</i> | | | |
| 5. SEX <i>F.</i> | 6. RACE <i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-3-97</i> | 9. AGE (In years lost birthday) <i>73</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MD.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Coleman</i> | | 14. MOTHER'S MAIDEN NAME <i>Etta Simms</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>James Barnes-1737 E. 30th St.</i> | |
| 18. <i>250.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pulmonary Embolus</i> DUE TO, OR AS A CONSEQUENCE OF: <i>CVA</i> (B) <i>Diabetic Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertension CV. ABVD</i> (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 15 1971</i> to <i>Jan 18 1971</i> , that (I) (we) lost saw the deceased alive on <i>Jan 18 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nathan E. Needle M.D.</i> | | 23B. DATE SIGNED <i>Jan 19/71</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>NATHAN E. NEEDLE</i> | | 23D. ADDRESS <i>6506 Park Heights Dr.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>1-23-71</i> | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>A. A. County, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1971</i> | 25B. NAME OF REGISTRAR <i>Robert A. Taylor</i> | 25C. FUNERAL DIRECTOR <i>Robert E. W. 1129 N. Calver St.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

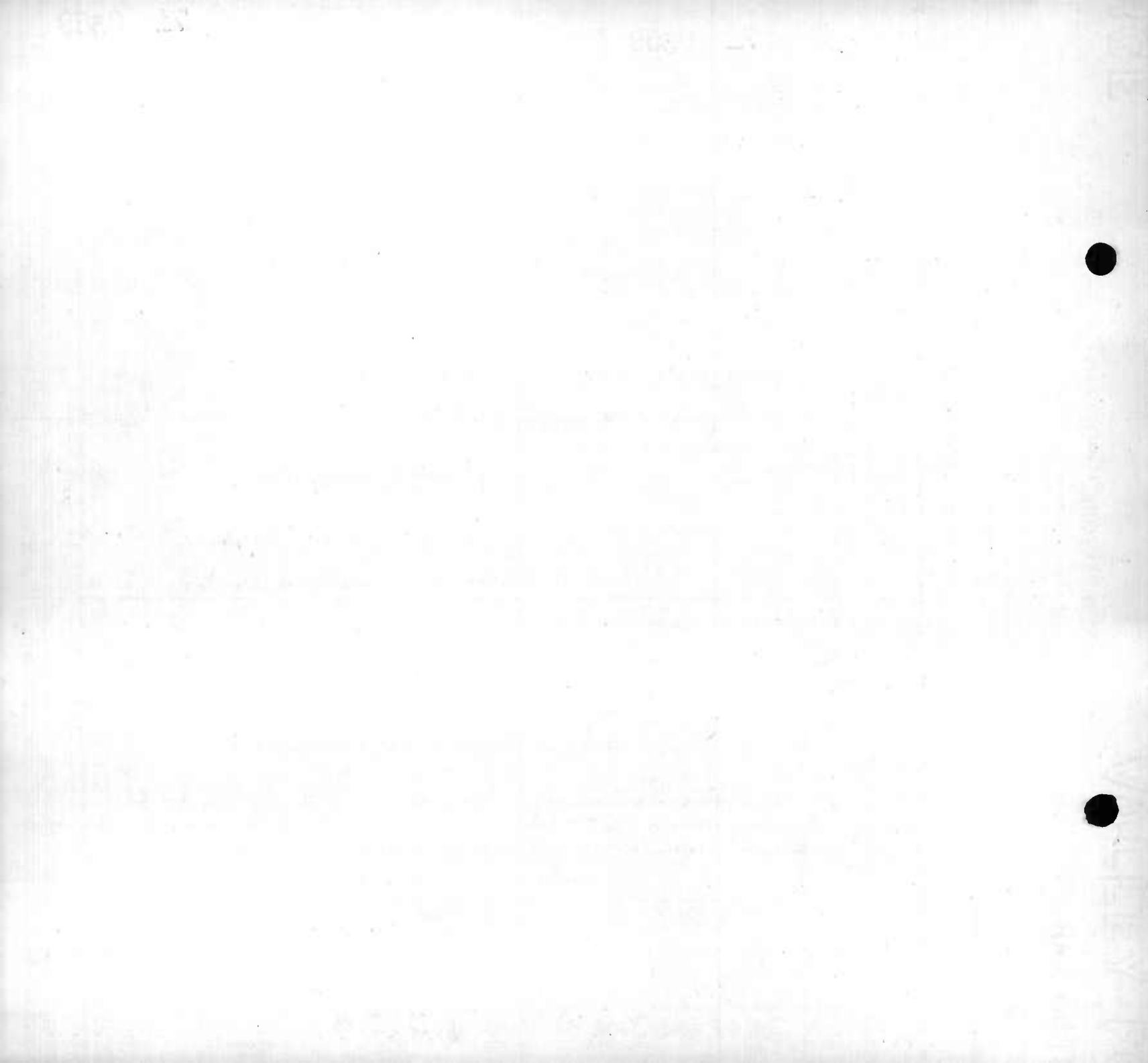
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|------------------------------------|---|--|
| C-380 71 0558 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0558 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>MABEL E. CATES</u> | | 2. DATE AND HOUR OF DEATH <u>1/16/71</u> <u>7:59</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> 4940 Eastern Ave. Balto., Md. 21224 | | E. STREET AND NUMBER <u>1242 N. GAY ST.</u> <u>21213</u> <u>007</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/10/25</u> | 9. AGE (In years last birthday) <u>45</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>THOMAS</u> | | 14. MOTHER'S MAIDEN NAME <u>LELA Pratt</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>BCH-Records</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md.</u> <u>21224</u> | |
| 18. <u>56971</u> CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE <u>Uncontrollable Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) <u>Upper Gastrointestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <u>Incisional Bleeding</u> <u>Duodenal cutaneous Fistula</u> <u>Chronic Liver Failure</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 19A. DATE OF OPERATION <u>12/14/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding</u> | |
| 19C. DATE OF OPERATION <u>12/14/71</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>12/12/70</u> to <u>1/16/71</u> and that (1) we last saw the deceased alive on <u>1/16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (the) (did) (the) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert Keith Fabric</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/16/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert Keith Fabric</u> | | 23D. ADDRESS <u>4940 Eastern Ave. Balto., Md. 21224</u> <u>Baltimore City Hospitals Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>12/24/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Beechwood Cemetery</u> | |
| 24D. LOCATION <u>Durham</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u> | | 24F. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u> | |
| 24G. FUNERAL DIRECTOR <u>ELLIOTT FUNERAL</u> | | 24H. ADDRESS <u>HOME</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | REG. NO. | 71 0559 |
|---|--|-------------------------|--|---|--|--|--|--|--|---|---------|
| 1-525 71 0559 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Denise Johnson | | | | 2. DATE AND HOUR OF DEATH 1-18-71 11:36 A.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1617 Abbottston St. | | | | | | | |
| 5. SEX Female | | 6. RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-10-53 | | 9. AGE (In years last birthday) 17 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY MD. | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Alvin Johnson | | | | 14. MOTHER'S MAIDEN NAME HEDY R. HORNE | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ALVIN T. JOHNSON 1617 ABBOTTSTON | | | | | |
| 18. 7969 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Lactic acidosis (B) Acute hemorrhagic gastroenteritis (C) 11 months post renal transplant | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 36 hrs | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION 1-14-71 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory laparotomy for FUO | | | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NO | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? NO | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-5 19 71 to 1-18 19 71 , that (I) (we) last saw the deceased alive on 1-18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Antonio Gonzalez-Revilla, Jr. M.D. | | | | | | | | 23B. DATE SIGNED 1-18-71 | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) Antonio Gonzalez-Revilla, Jr. M.D. | | | | | | | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 1/22/71 | | 24C. NAME OF CEMETERY or CREMATORY MT. AUBURN CEM | | | | 24D. LOCATION (City, town, or county) (State) BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | | | 25B. NAME OF REGISTRAR Barbara J. B. King | | | | 25C. FUNERAL DIRECTOR Wm. C. March | | ADDRESS 928 E NORTH | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 88671 0360 | |
|---|----------------|---|---|--|---|
| T-631 71 0360 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | TROUTFELTER, Thomas | | 12 Jan 71 0200 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW NCC | | | A. STATE Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 712 S. Port Street | | |
| 5. SEX M | 6. RACE Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-20-11 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Thomas Troutfelter | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. None 09-4949 | | 17. INFORMANT MRS. MATILDA TROUTFELTER 712 S. Port St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) TERMINAL CA - Prostate | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pro C. V. A. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: Pro. Broncho-Pneumonia | | 2 weeks. | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: A.S. C. V. D. | | | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/6 to 1/12 1971 that (I) (we) last saw the deceased alive on 1/6 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Mamari L. Mamaril | | | 23B. DATE SIGNED 1/12/71 | | 23C. PHYSICIAN'S NAME (Type) Dr. Mamaril |
| 23D. ADDRESS 1115 A. CALVERT ST. | | | 23E. DEGREE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/15/71 | | 24C. NAME of CEMETERY or CREMATORY GARDENS OF FAITHS CEM. | |
| 24D. LOCATION BALTIMORE CO. M.D. | | 24E. NAME of REGISTRAR RAYMOND L. KACZOROWSKI | | 24F. FUNERAL DIRECTOR 2525 FLEET ST. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |

1955 11

1960 12

1965 13

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---------|--|--|--|------------------|--|
| B-653 | | 71 0561 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0561 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) Joseph J. Bernadzikowski (Barnes) | | | |
| 2. DATE AND HOUR OF DEATH 18 January 1971 | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2224 Fleet Street | | | |
| 6. CITY OR TOWN Baltimore | | | | 7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 8. STREET AND NUMBER 2224 Fleet Street | | | | 9. SEX male 10. RACE Cauc. 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 12. DATE OF BIRTH 16 Mar. 1897 | | | | 13. AGE (In years last birthday) 73 | | | |
| 14. BIRTHPLACE (State or foreign country) Maryland | | | | 15. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 16. FATHER'S NAME Frank Bernadzikowski | | | | 17. MOTHER'S MAIDEN NAME Mary Rusin | | | |
| 18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I | | | | 19. SOCIAL SECURITY NO. 218 01 1973 | | | |
| 20. INFORMANT Mrs. Lillian Bernadzikowski | | | | 21. ADDRESS same | | | |
| 22. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the Lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 3 mo. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 26. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 19D. TIME OF INJURY (Month) (Day) (Year) (Hour) 19E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 19F. HOW DID INJURY OCCUR? 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | 20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21. I certify that (1) (this hospital) attended the deceased from Oct 30 1970 to Jan 18 1971 that (1) (we) last saw the deceased alive on Jan 15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | 22. SIGNATURE Walter R. Welzant 23. PHYSICIAN'S NAME (Type) Walter R. Welzant, M. D. 24. ADDRESS 422 Medical Arts Bldg. Balto. Md. 21201 | | | |
| 25. DATE REC'D BY HEALTH DEPT. JAN 20 1971 | | | | 26. NAME OF REGISTRAR Raymond P. Kaczorowski | | | |
| 27. DATE 22 Jan. 1971 | | | | 28. LOCATION Baltimore Ct. Maryland | | | |
| 29. NAME OF CEMETERY or CREMATORY Holy Rosary | | | | 30. DATE SIGNED Jan 19, 1971 | | | |
| 31. DATE 22 Jan. 1971 | | | | 32. ADDRESS 2525 Fleet St. # 24 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

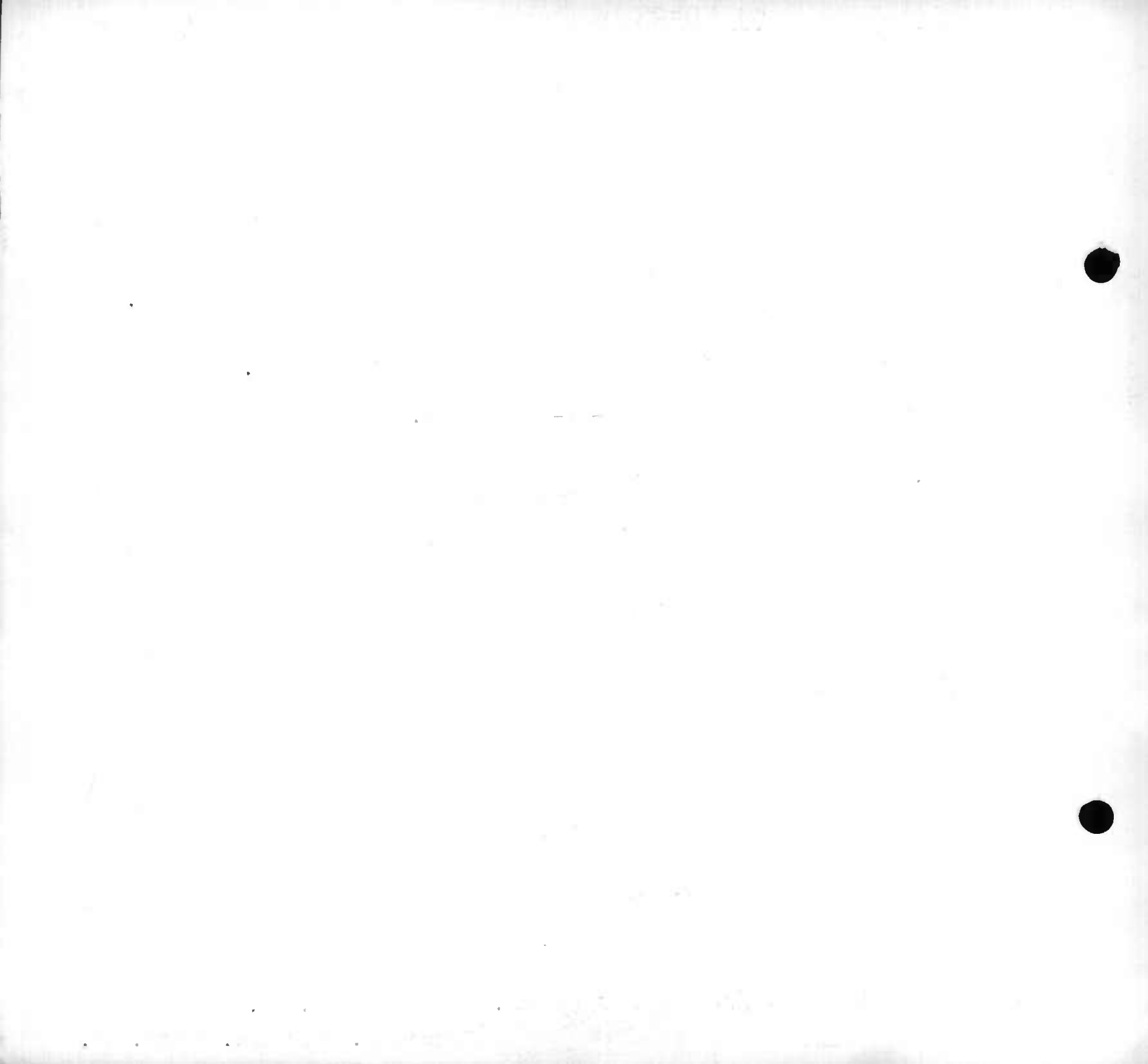
| Baltimore City Health Department | | | | 71 0562 | | 71 0562 | |
|---|---------------------|--|--------------------------------------|--|---|---|-----------------------------|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>IRANN POLUH</u> | | | | 2. DATE AND HOUR OF DEATH <u>1-17-71</u> <u>10:10</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Bolton Hill Nursing Home</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>MD.</u> | | B. COUNTY <u>1903</u> | |
| C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER <u>1749 WILKINS AVE</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-24-1882</u> | 9. AGE (in years last birthday) <u>88</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <u>Bolton Hill Nursing Home - 1400 Forest</u> | | | |
| 18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral ARREST</u> (B) <u>A.S.C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>C.B.D. - Senility</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>?</u> <u>?</u> | |
| MEDICAL CERTIFICATION | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> 19 <u>70</u> to <u>1/17</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>1/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Joseph S. Blum</u> | | | | 23B. DATE SIGNED <u>1/17/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1-20-71</u> | | 24C. NAME OF CEMETERY or CREMATOR | | 24D. LOCATION (City, town or county) (State) | |
| 25A. DATE REC'D. BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>JOHNS HOPKINS MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u> | | | |



Released by Medical Examiner on approval of funeral director. This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

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|---|--|--|--|--|--|---|--|
| B-543 | | 71 0563 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0563 | |
| BIRTH NO. | | | | 1 | | | |
| 1. NAME OF DECEASED (Type or Print) REYNOLDS, MARGARET W. | | | | 2. DATE AND HOUR OF DEATH 1/14/71 4:10 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Baltimore Md. 2004 Hellenwood Road | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-18-9 | |
| 9. AGE (In years last birthday) 79 | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NEW JERSEY | |
| 12. CITIZEN OF WHAT COUNTRY USA AMERICAN | | 13. FATHER'S NAME JOSEPH B. WENTZELL | | 14. MOTHER'S MAIDEN NAME KEENE E. UAI. | | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. 214-01-9349D | | 17. INFORMANT Mrs. Margaret Peddicord same | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month. | |
| 19A. DATE OF OPERATION 12-16-70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SATISFACTORY | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour () | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12/16/70 to 1/14/71 that (I) (we) last saw the deceased alive on 1/14/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Joni M. [Signature] DEGREE | |
| 23B. DATE SIGNED 1/14/71 | | 23C. PHYSICIAN'S NAME (Type) [Signature] DEGREE | | 23D. ADDRESS [Signature] DEGREE | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 1/16/71 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 24D. LOCATION Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | |
| 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | 25D. ADDRESS [Signature] | | 25E. DATE JAN 21 1971 | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0564 | | | |
|--|--|--|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | Keith E. Taylor | | 2. DATE OF DEATH | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD | | Month 1 Day 17 Year 71 Hour 7:40 p.m. | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| Md. | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| male | | White | | Balto. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 6. SEX | | 7. RACE | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN | |
| | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) | | E. STREET AND NUMBER | | | |
| Oct. 11, 1913 | | 57 | | 3113 Texas Avenue | | | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | |
| Iowa | | USA | | Elmer Keith Taylor | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | | |
| Foreman | | Rubber Co. | | Cynthia | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | ADDRESS | |
| yes WW2 | | 214-26-4470 | | Mrs. Grace E. Taylor same | | | |
| 19. CAUSE OF DEATH | | Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | |
| | | | | NO | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED | | 22F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 23. | | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Notual causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 1/18/71 | |
| Peter Lipkovic, M.D. | | | | ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 1/22/71 | | Cedar Hill | | Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 21 1971 | | Robert E. Taylor | | Leonard J. Ruck Inc. Balto. Md. | | | |

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| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 71 0565 | |
|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Eugenia JEAN GEORGE | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 15 1971 8:50 p.m. | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-02 | | | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 6. SEX female | | 7. RACE white | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER 827 St. Paul St. | |
| 9. DATE OF BIRTH Jan. 4, 1919. | | 10. AGE (In years last birthday) 52 | | 11. BIRTHPLACE (State or foreign country) Boston, Mass. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Alexander J. McInnis | | | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | |
| 15. MOTHER'S MAIDEN NAME Julia H. McCarthy | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 17. SOCIAL SECURITY NO. | | | | 18. INFORMANT ADDRESS Mr. Meredith George (Same) | | | |
| 19. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/19/71. | | 24C. NAME of CEMETERY or CREMATORY Milton Cemetery | | 24D. LOCATION (City, town, or county) (State) Milton, Mass. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Rebel E. Galy... | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. | | ADDRESS Balto. Md. 2121 | |

1950

1950

ACADEMIC BOND

1950

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT 71 0566 CERTIFICATE OF DEATH | | | | REG. NO. 71 0566 | |
|---|------------------|--|----------------------------|---|---|
| BIRTH NO. B-236 | | 1. NAME OF DECEASED (Type or Print) EDWARD C. BAXTER | | 2. DATE AND HOUR OF DEATH January 14, 1971 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4916-Marluth Ave. 5916 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 26-31 C. CITY OR TOWN Baltimore, D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER X 5916 Marluth Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/2/85 | 9. AGE (in years last birthday) 85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William Baxter | | 14. MOTHER'S MAIDEN NAME Louisa Whittle | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No | | 16. SOCIAL SECURITY NO. 212 10 6483 | | 17. INFORMANT ADDRESS Mrs. Luella Baxter 5916 Marluth Ave. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Advanced Arteriosclerosis to heart (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 1/10 to 1/14 19 71 that (I) (we) last saw the deceased alive on 1/5 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE L.B. Stevens | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) Dr. L.B. Stevens | |
| 23D. ADDRESS 3500 Erdman Ave., Balto. Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/18/70 | |
| 24C. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery | | 24D. LOCATION (City, town, or county) (State) Finksburg, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | |
| 25B. NAME OF REGISTRAR Robert E. J. J. J. | | 25C. FUNERAL DIRECTOR Deborah J. Ruck Inc., Balto. Md. | | 25D. ADDRESS 21214 | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| A-141 | | 71 0567 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0567 | |
|---|-----------------------|---|--|--|--|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MILDRED S. APPLEBY | | | | 2. DATE AND HOUR OF DEATH JAN 16, 71 11:55 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp. | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1650 North Boune Rd. | | | |
| 5. SEX F | 6. RACE CAC | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/28/03 | 9. AGE (in years last birthday) 67 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME CLARK K. Strasburg | | | |
| 14. MOTHER'S MAIDEN NAME MARGARET ALLEN | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 215-22-2216 | | | | 17. INFORMANT ADDRESS EDWARD APPLEBY (Same) | | | |
| 18. CAUSE OF DEATH 4319 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pneumonia | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emboli | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Y.S. | | | |
| (C) _____ | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 12/17/70 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUBDURAL HEMATOMA HEMORRHAGE | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/9/70 19 to 1/16/71 19 that (I) (we) last saw the deceased alive on 1/16/71 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H. J. Wademan, M.D. | | | | 23B. DATE SIGNED 1/16/71 | | 23C. PHYSICIAN'S NAME (Type) ROSS L. WADEMAN, M.D. | |
| 23D. ADDRESS Union Memorial Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/20/71 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Hickey, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

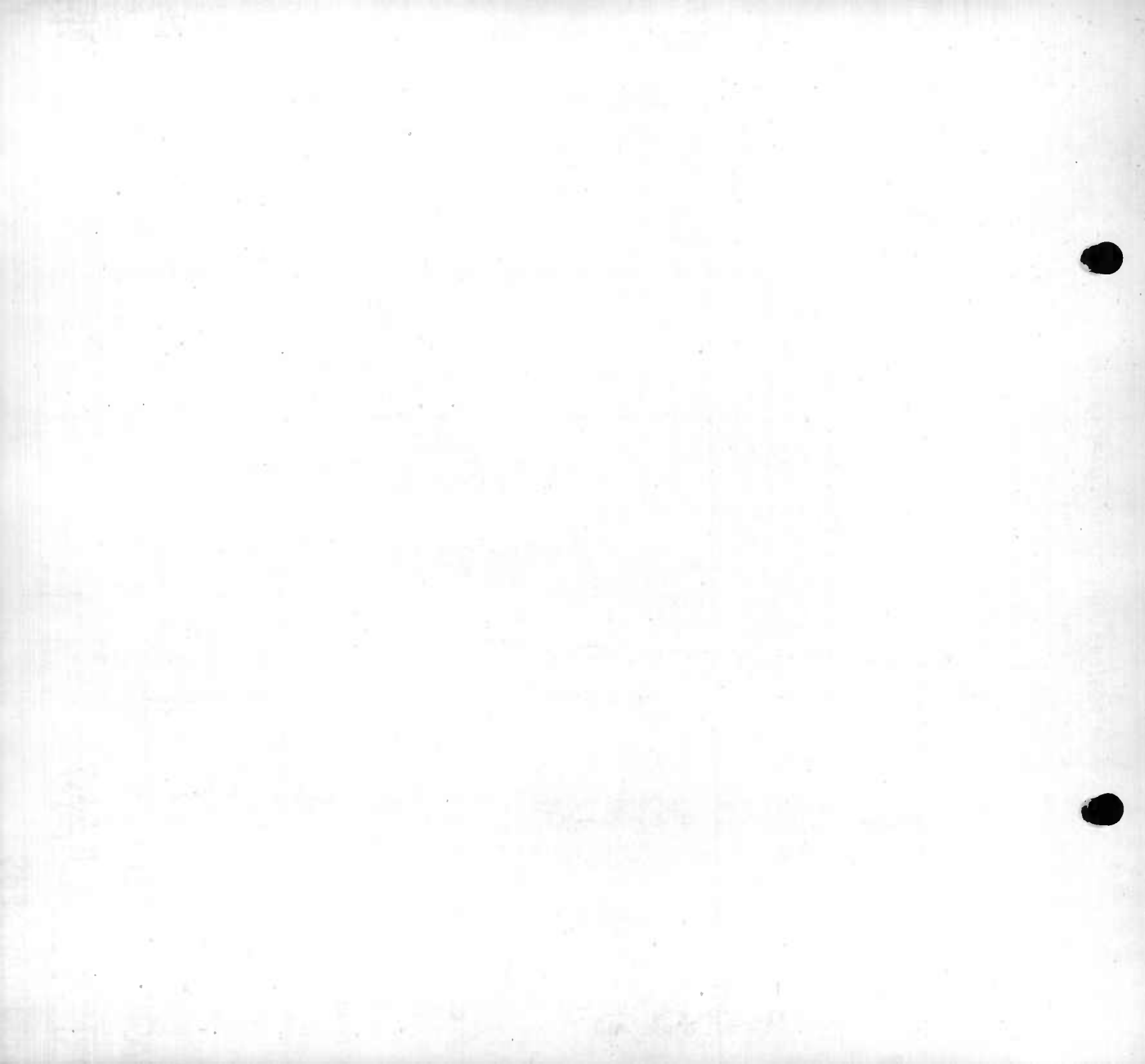
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0568 | |
|---|---|---|--|--|---|
| BIRTH NO. 8-240 71 0568 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ROSELLA ELIZABETH RUSSELL | | | 2. DATE AND HOUR OF DEATH January 16, 1971. 11:30 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1638 Waverly Way | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 27-58 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1638 Waverly Way | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 1, 1892. | 9. AGE (In years last birthday) 78 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Albert Keys | | |
| 14. MOTHER'S MAIDEN NAME ? Shipley | | | 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 217-14-6660J1 | | | 17. INFORMANT Mr. Gerald Russell | | |
| 18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from Nov 14 1970 to Jan 16 1971 that (I) (we) last saw the deceased alive on Jan 14 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Frederick J. Vollmer M.D. 23B. DATE SIGNED 1-18-71 23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER M.D. 23D. ADDRESS 6100 York Rd 21212 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/20/71. 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 25B. NAME OF REGISTRAR Robert E. ... 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

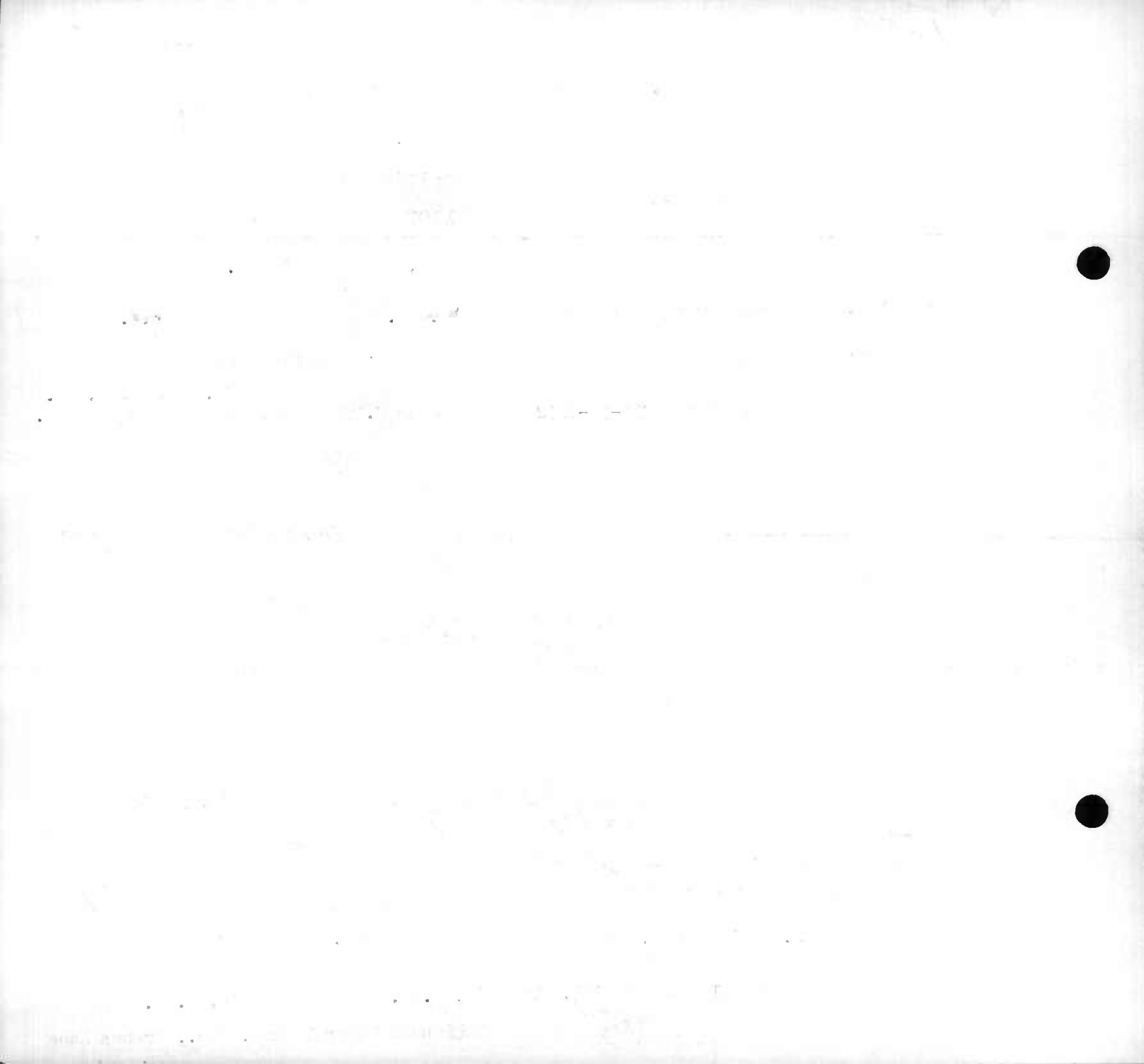
| Baltimore City Health Department | | | | REG. NO. 71 0569 | |
|--|--|--|--|--|--|
| T-634 71 0569 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Mary Alice Treadwell | | | 2. DATE AND HOUR OF DEATH 1/18/71 1:30 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Pine Ridge Nursing Home 4703 Hamphelt Ave Baltimore Md 21214 | | | A. STATE Md. 8. COUNTY 12-02 | | |
| 5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | E. STREET AND NUMBER 3311 Guilford Ave. 4703 Hamphelt Ave | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 8. DATE OF BIRTH May 27, 1872 9. AGE (In years last birthday) 98 28x | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Samuel T. Denbow | | | 14. MOTHER'S MAIDEN NAME Catherine Streidhuff | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mrs. M. Willene Mitchell | | | ADDRESS (Same) | | |
| 18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 25 19 69 to January 18 1971, that (I) (we) last saw the deceased alive on January 18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Edward J. Alessi | | | | 23B. DATE SIGNED 1/18/71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Edward J. Alessi | | | | 23D. ADDRESS 6217 Harford Rd, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/20/71 | | 24C. NAME OF CEMETERY OR CREMATORY Fallston Methodist Cemetery | |
| 24D. LOCATION Fallston, Md. | | 24E. NAME OF REGISTRAR Leonard J. Ruck, Inc.-Balto, Md.-14 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.-Balto, Md.-14 | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Balto, Md.-14 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

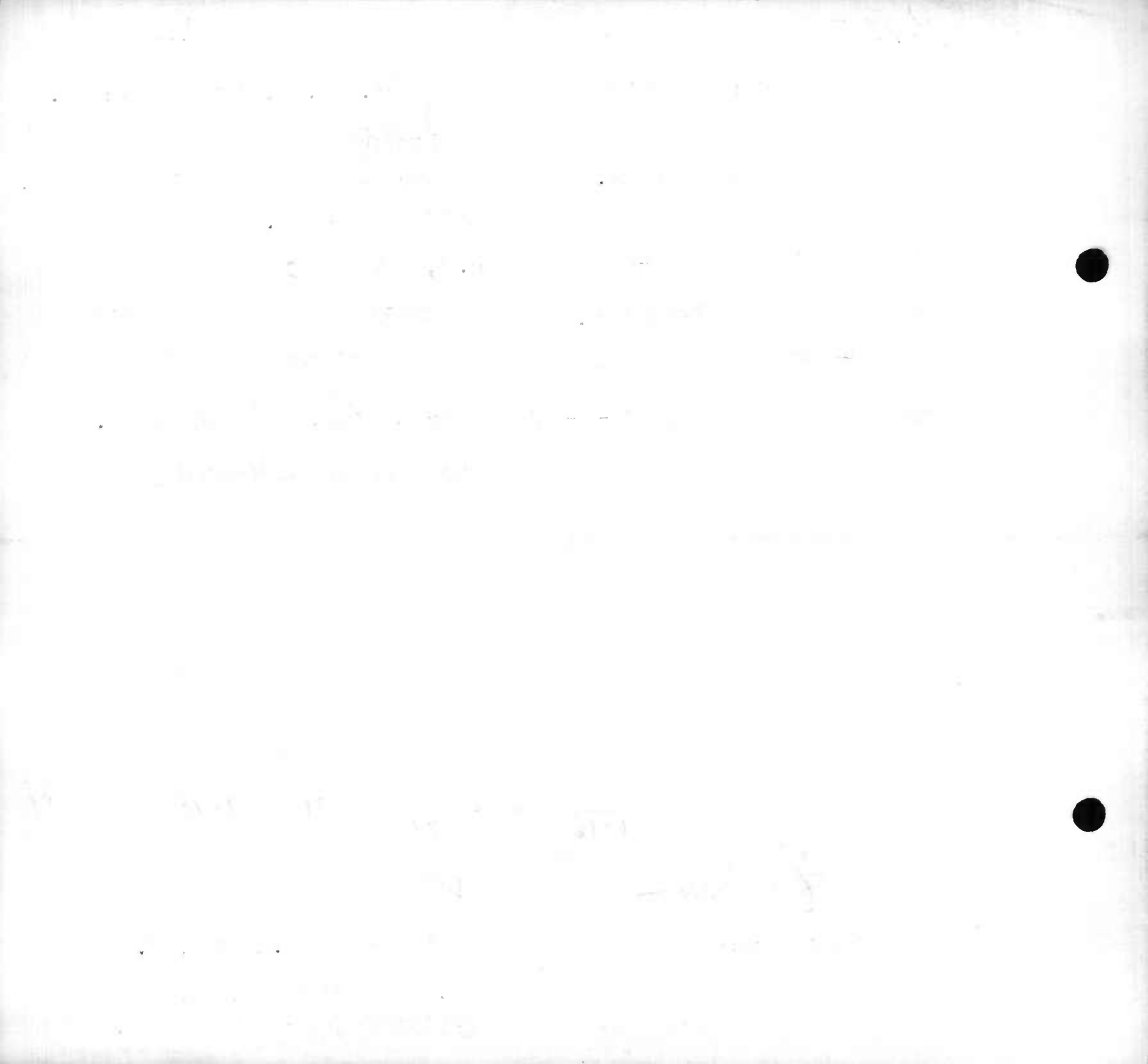
| | | | |
|--|--|---|--|
| T-512 71 0570 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| BIRTH NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| CHARLES L. THOMPSON | | 1/16/71 10:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE B. COUNTY | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | Md. 14-01 | |
| 00 1207 Bolton Street | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | |
| | | 1207 Bolton Street | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | May 28, 1929 |
| | | 9. AGE (In years last birthday) 41 yrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| Sales Representative | | W. Va. | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| United Air Lines | | U.S. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Leslie Thompson | | Bessie Van Devander | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Korean Korean | | 233-38-2432 | |
| 17. INFORMANT | | ADDRESS | |
| John W. Thompson, 2012 Washington Ave. | | St. Albans, W. Va. | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | immediate | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES | | acute myocardial infarction | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) coronary sclerosis 5 yrs | |
| | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 2 prior myocardial infarctions | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/4/65 19 to 1/16/71 19 that (I) (we) lost saw the deceased alive on 1/17/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Dr. William F. Renner | | 1/17/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Dr. William F. Renner | | 3222 St. Paul Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| burial | 1/19/71 | Cedar Hill, Franklin, W. Va. | Franklin, W. Va. |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 21 1971 | Robert E. Kelly, Jr. | Schumaker Funeral Home, Inc., Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

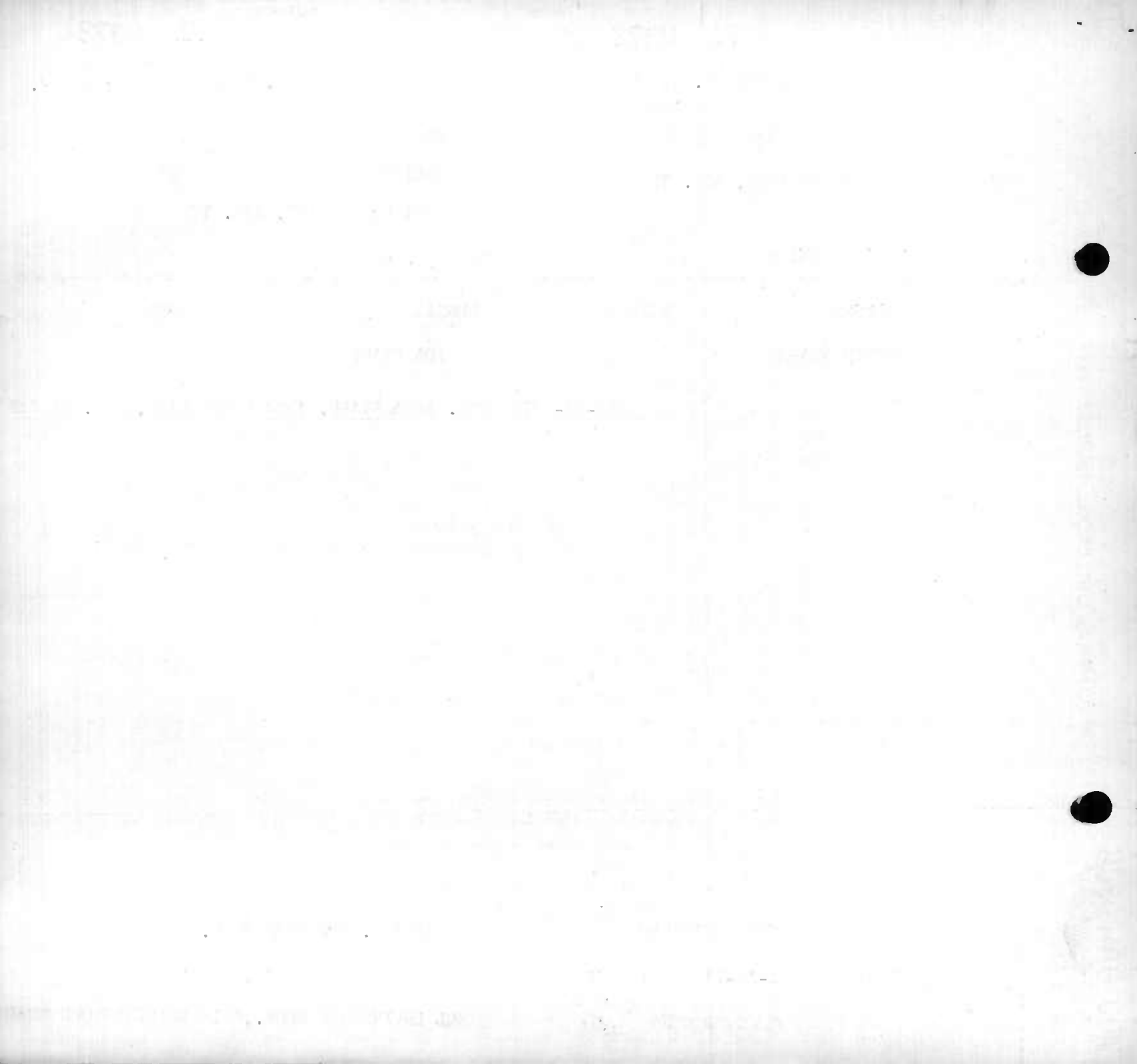
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0571 | |
|--|---|---|--|--|---|
| BIRTH NO. P-435 71 0571 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Francisco Pallottine | | | 2. DATE AND HOUR OF DEATH Sat. Jan. 16, 1971 6:30 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-31 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3446 Woodstock Ave. | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER 3446 Woodstock Ave. | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 4, 1887 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Esskay & Co. | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 12. CITIZEN OF WHAT COUNTRY? Italy | | | | | |
| 13. FATHER'S NAME unknown | | | 14. MOTHER'S MAIDEN NAME unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 216-01-5977 | | 17. INFORMANT (daughter) ADDRESS Clara Collitto, 3446 Woodstock Ave. | |
| 18. CAUSE OF DEATH 1571.9 I | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Adeno Carcinoma Stomach | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1-16 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-16 19 71 to 1-16 19 71 and that (I) (we) last saw the deceased alive on 1-16 19 71 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sebastian Russo | | | 23B. DATE SIGNED 1/19/71 | | |
| 23C. PHYSICIAN'S NAME (Type) Sebastian Russo | | | 23D. ADDRESS 5017 Harford Ave., Balto, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/19/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem. | |
| 24D. LOCATION Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Schumnek Funeral Home, Inc. | |
| | | | | ADDRESS 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

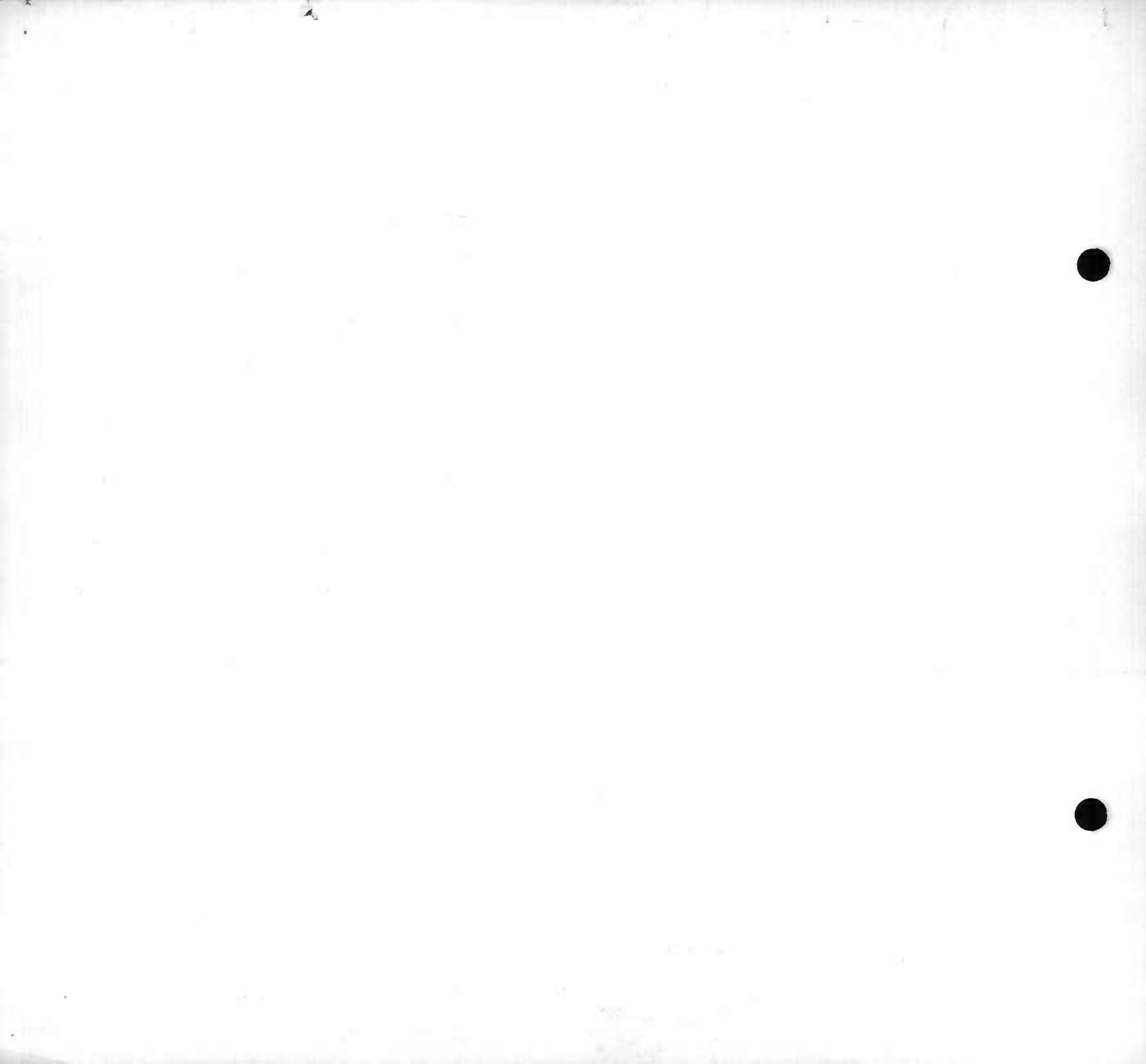
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0572 | |
|--|---|--|---------------------------------------|--|-----------------------------|
| S-360 71 0572 CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| IRVING M. STARR | | JANUARY 17, 1971 | | 4:45 P. M. | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| A. STATE MARYLAND | | B. COUNTY BALTIMORE | | | |
| C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 4004 FORDS LANE, APT. TC | | | | | |
| 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 1, 1898 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME MORRIS STARR | | | |
| 14. MOTHER'S MAIDEN NAME IDA STARR | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 215-09-6972 | | 17. INFORMANT MRS. ANNA STARR, 4004 FORDS LANE, APT. TC #15 | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 19. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: M I H A S H I D | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 12 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/19/55 to 1/17/71, that (I) (we) lost the deceased alive on 1/17/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE ISRAEL ZINBERG | | 23B. DATE SIGNED 1/18/71 | | 23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG | |
| 23D. ADDRESS 4000 W. NORTHERN PKWY. | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 1-19-71 | | 24C. NAME of CEMETERY or CREMATORY BETH TFILOH | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR SOL LEVINSON | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

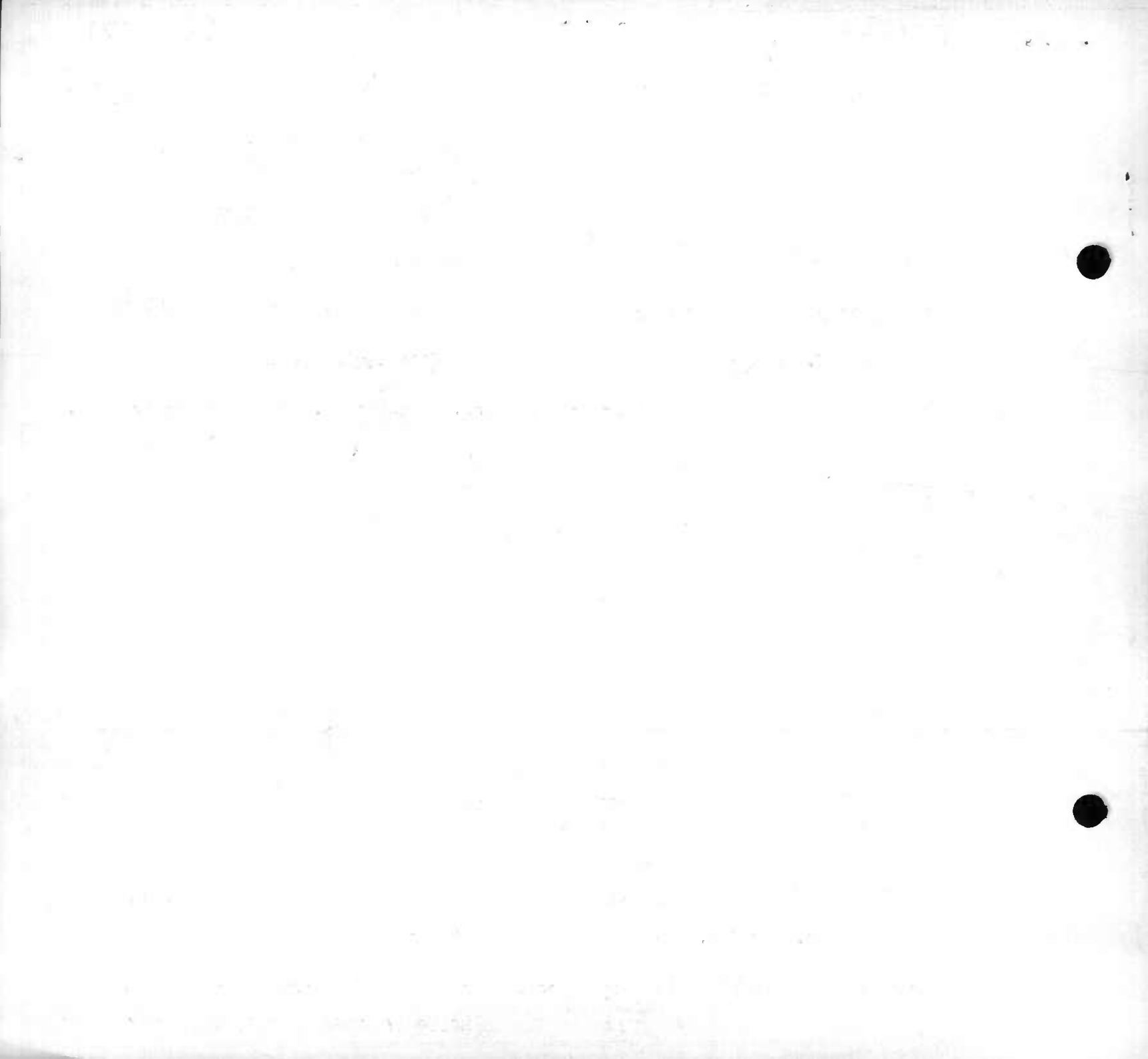
| | | | | | | | |
|---|------------------|---|----------------------------------|--|---|--|--|
| BIRTH NO. 8-425 | | 71 0573 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0573 | |
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Franklin Rolason</u> | | | | 2. DATE AND HOUR OF DEATH <u>1-17-71</u> <u>3:05</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Bolton Hill Nursing Home</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Mo.</u> B. COUNTY <u>13-07</u> | | | |
| C. CITY OR TOWN <u>Baltimore</u> | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER <u>3815 Roland Ave - 21211</u> | | | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-1-1909</u> | 9. AGE (In years last birthday) <u>61</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Farm Industry</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>? Myers</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>214-14-6364</u> | | 17. INFORMANT <u>Bolton Hill Nursing Home - 1400 John St</u> | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>115X1</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>Histoplasmosis</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>Chronic Pulmonary</u> <u>(C) Antecedent</u> <u>CV disease</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1964</u> <u>years</u> <u>years</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> 19 <u>71</u> to <u>1/17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | 23B. DATE SIGNED <u>1/18/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Alan H. Maentz MD</u> | | | | 23D. ADDRESS <u>2 E Real St Baltimore 21202</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/20/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Donovan Funeral Home</u> | | ADDRESS <u>3818 Roland Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

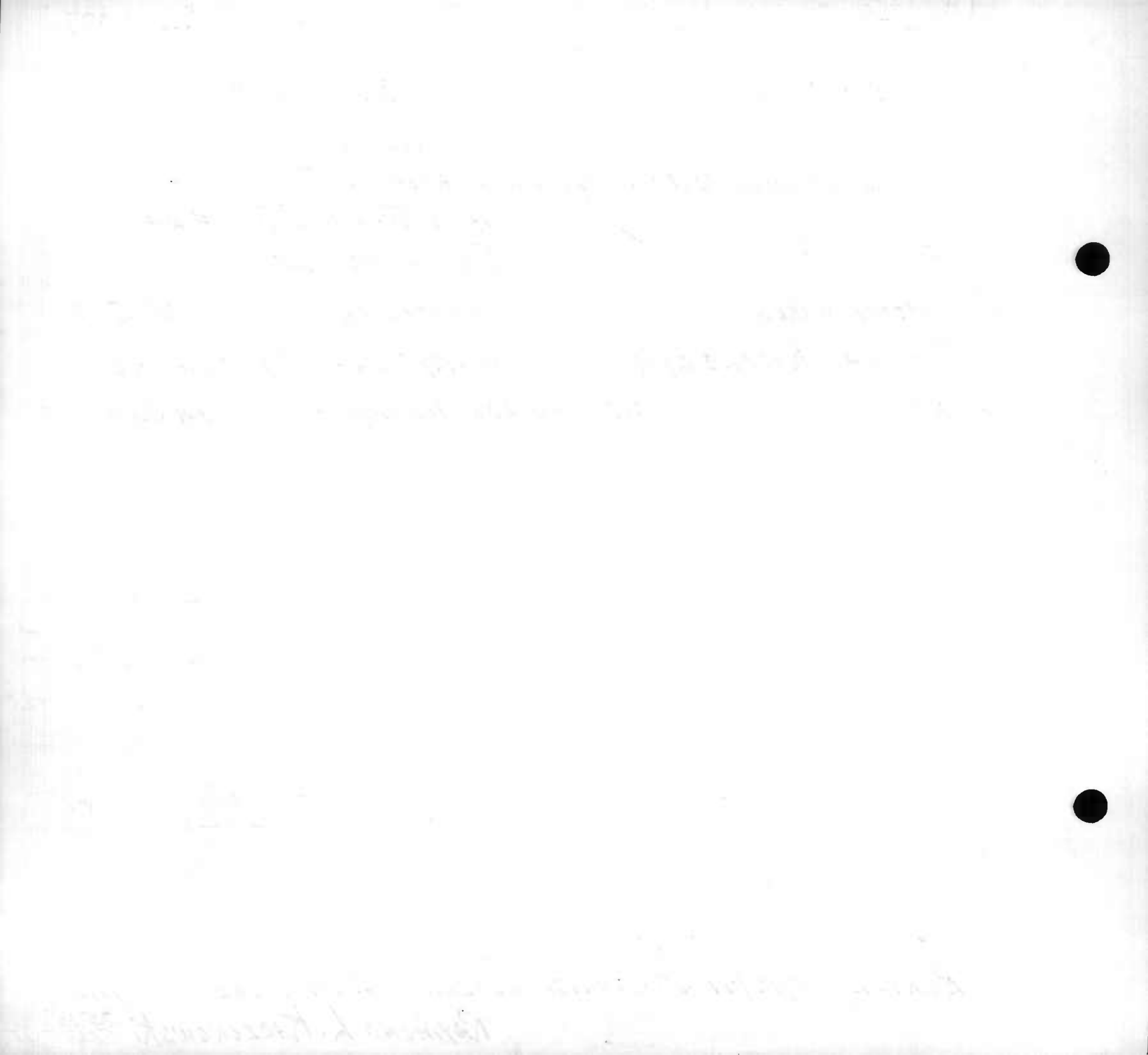
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 0574 | |
|---|--|--|--|--|--|---|--|
| F-652 | | 71 0574 | | 1. NAME OF DECEASED (Type or Print) JAMES FRANCE | | 2. DATE AND HOUR OF DEATH 1/15/71 6:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY HOSPITAL 38 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY WICOMICO 72-12 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL | | | | C. CITY OR TOWN SALISBURY | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 9/10/04 | | 9. AGE (in years last birthday) 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter | | | | 10B. KIND OF BUSINESS OR INDUSTRY Boilers | | 11. BIRTHPLACE (State or foreign country) USA, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME William T. France | | | |
| 14. MOTHER'S MAIDEN NAME Etta Louise Jones | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 217-03-8647 | | | | 17. INFORMANT (Wife) Mrs. Elizabeth A. France, Salisbury, Md. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc., it means the disease, injury or complication which caused death.) ACUTE SUBDURAL HEMATOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE SUBDURAL HEMATOMA | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10d. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 1/6/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUBDURAL HEMATOMA | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Tramway | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) SALISBURY 3115 SHANNON ST | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 1 - 6 - 71 4:00 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell down stairs, hit head | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/5/71 19 70 to 1/15 19 71 that (I) (we) last saw the deceased alive on 1/15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David M. Cook | | | | 23B. DATE SIGNED January 15, 1971 | | 23C. PHYSICIAN'S NAME (Type) Dr. David M. Cook | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/18/71 | | 24C. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | 24D. LOCATION (City, town, or county) (State) Salisbury, Wicomico, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR John E. ... | | 25C. FUNERAL DIRECTOR ADDRESS HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

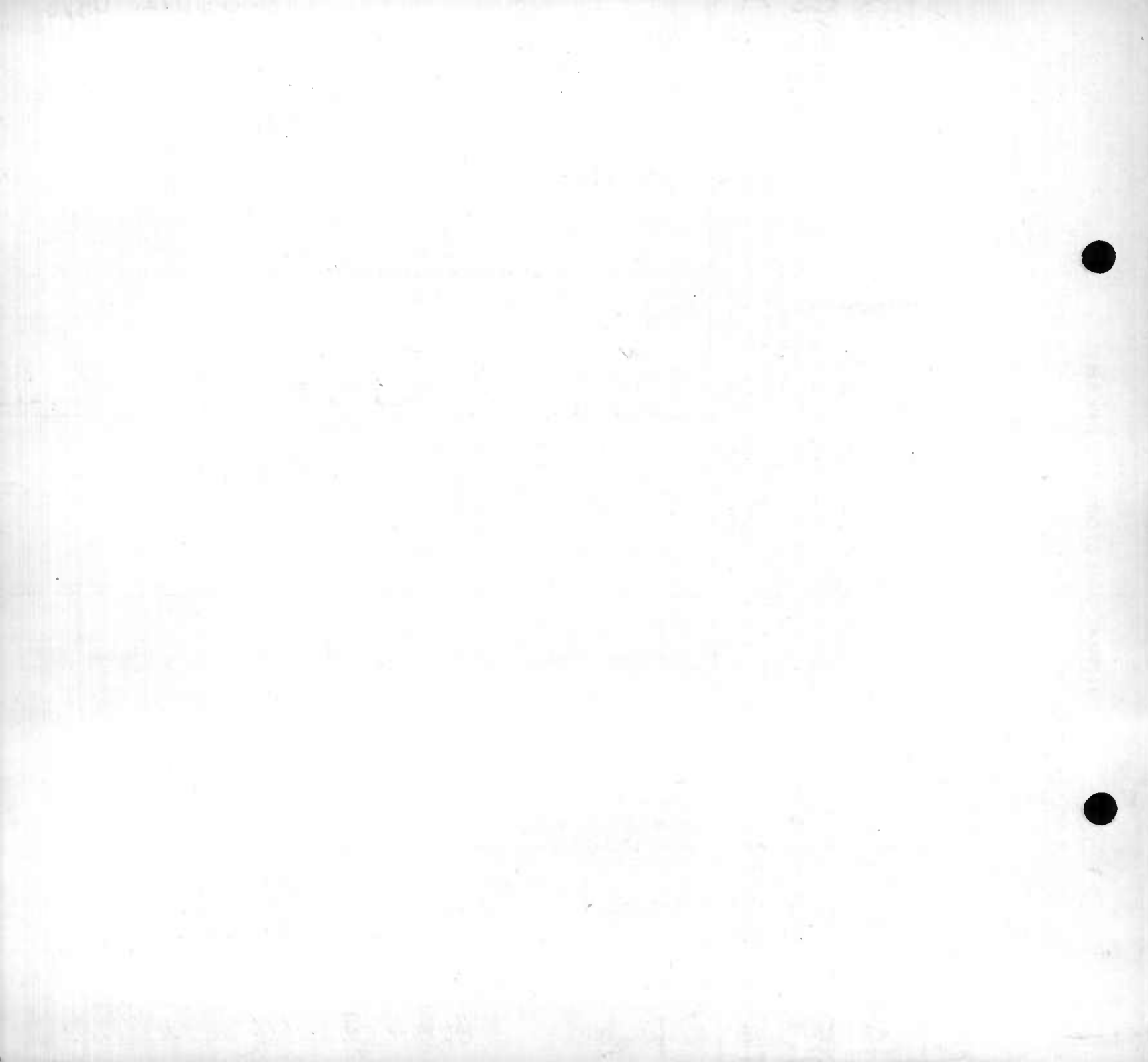
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0575 | | REG. NO. 71 0575 | |
|--|----------------------|---|--|--|---|---|--|
| S-562 71 0575 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ROSE B. SMIAROWSKI | | | | 2. DATE AND HOUR OF DEATH JAN 8 1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 26-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE City Hospital | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 31 | | | | E. STREET AND NUMBER 421 JOPLIN ST. | | #24 | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 26, 1902 | 9. AGE (In years last birthday) 68 | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME JOSEPH KROLCZYK | | | | 14. MOTHER'S MAIDEN NAME MARYANNA SYNORACKO | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 218-03-3950 | | 17. INFORMANT MR. Jos. Smiarowski | |
| 18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis Secondary to A.C.U.P. | | | | CAUSE OF DEATH Coronary Thrombosis Secondary to A.C.U.P. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1 1968 to 1/8 1971 that (I) (we) last saw the deceased alive on Oct 1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph R. Liberto M.D. | | | | 23B. DATE SIGNED 1/9/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH B. LIBERTO M.D. | | | | 23D. ADDRESS 3508 Birch St. Baltimore Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/12/71 | | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cem. | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Raymond K. Kaczorowski | | 25C. FUNERAL DIRECTOR Raymond K. Kaczorowski | | ADDRESS 5525 Fleet St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

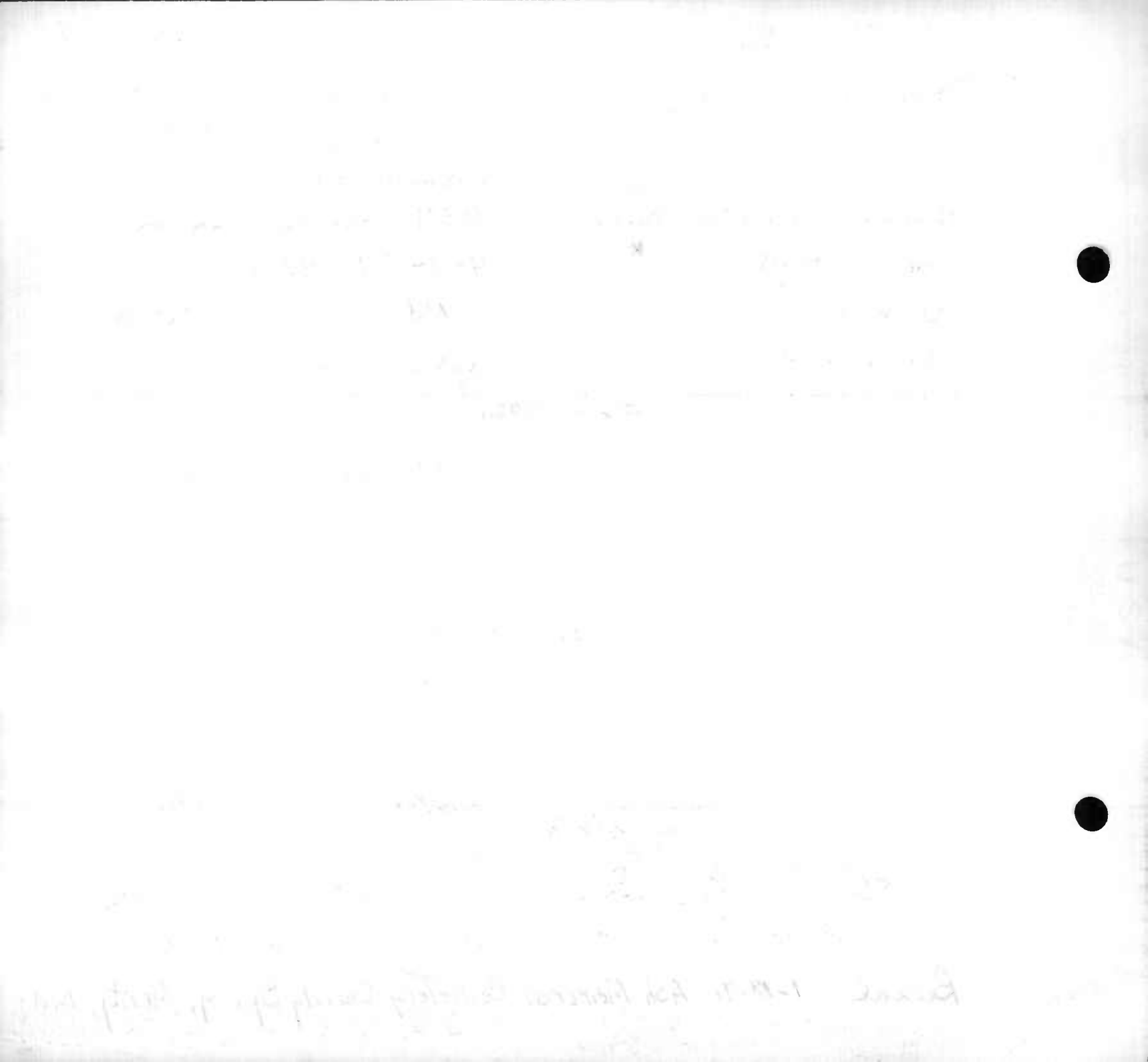
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0576 | | 71 0326 | |
|--|---------|---|------------------|---|----------------------------|--|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Scheiner, Charles P. | | | | 1/16/71 1:20 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| Union Memorial Hosp. | | | | Maryland Baltimore 27-44 | | | |
| 44 | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | |
| | | | | Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER | | | | 3011 Mary Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| Male | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 05-02-04 | 66 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| PREACHER | | | | Maryland | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George Scheiner | | | | Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | 219-07-0319 | | Charles P. Scheiner Jr. 6108 (28) WHEATLAND | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| 492.8 | | | | Emphysema | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | Focal myocardial infarction | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | Cerebrum | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| Y.S. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | | | White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospito) attended the deceased from 1/16/71 19 71 to 1/16 19 71, that (I) (we) lost saw the deceased alive on 1/16 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| H. Earl Cotman, M.D. | | | | 1/16/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| H. EARL COTMAN, M.D. | | | | Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | | | 1/19/71 | | Wessups Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | | | 24E. FUNERAL DIRECTOR | | 24F. ADDRESS | |
| Cockeysville BALTI. Co. Md. | | | | Byrger Funeral Home | | Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 21 1971 | | | | R. E. E. E. E. | | Byrger Funeral Home | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0577 | | 71 0577 | |
|---|-------------------------|---|--|---|---|--|--|
| BIRTH NO. | | | | 71 0577 | | 71 0577 | |
| 1. NAME OF DECEASED (Type or Print) <u>Robinson, Doris</u> | | | | 2. DATE AND HOUR OF DEATH <u>1-14-71</u> <u>19:20 A.M.</u> | | | |
| 3. PLACE (IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD) FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4017 Liberty Ave</u> <u>Canada Nursing Home</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Montgomery</u> C. CITY OR TOWN <u>Takoma Park</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>937 Houston Street</u> | | | |
| 5. SEX <u>Fe</u> | 6. RACE <u>Black</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-4-87</u> | 9. AGE (In years last birthday) <u>83 yrs.</u> | 10. Under 1 Yr. Months Days If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>Unknown</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | |
| 16. SOCIAL SECURITY NO. <u>216-22-0592A</u> | | | 17. INFORMANT ADDRESS | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>153.81</u> <u>CARCINOMA OF COLON</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Decubiti Ulcers</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | 20. DATE OF OPERATION | | | |
| 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 22. AUTOPSY? (Yes or No) <u>No</u> | | 23. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 27. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 29. HOW DID INJURY OCCUR? | |
| 30. I certify that (I) (this hospital) attended the deceased from <u>3/14/70</u> 19 to <u>1/14/71</u> 19 that (I) (we) last saw the deceased alive on <u>1/14/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 31. SIGNATURE <u>HOLLIS DENNALINE</u> | | | | 32. DATE SIGNED <u>1/14/71</u> | | 33. PHYSICIAN'S NAME (Type) <u>HOLLIS DENNALINE</u> | |
| 34. ADDRESS <u>1801 GREENBERRY Rd, Balt, Md</u> | | | | 35. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 36. DATE <u>1-18-71</u> | | | | 37. NAME of CEMETERY or CREMATORY <u>Ash Memorial Cemetery</u> | | 38. LOCATION (City, town, or county) (State) <u>Sandy Spring, Montg, Md</u> | |
| 39. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | | | 40. NAME OF REGISTRAR <u>R. J. ...</u> | | 41. FUNERAL DIRECTOR <u>R. J. ...</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0578

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOHN XXXXXXXX Terziu | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 16 1971 4:15 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 10/26/1918 | | 10. AGE (In years last birthday) 52 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Terziu | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Man | |
| 15. MOTHER'S MAIDEN NAME ? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes WW77 | |
| 17. SOCIAL SECURITY NO. 453-20-0467 | | 18. INFORMANT Mrs. Veronica Terziu | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Isidore Mihalakis</i> M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-17-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/19/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR John A. Moran, Inc. | |
| 25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St | | | |

3730 IN

MADE IN U.S.A. - 100% COTTON

WALFENBUTTEL

MADE IN GERMANY

WALFENBUTTEL

WALFENBUTTEL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0579 | |
|---|---|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Mrs. Marie Weslow | | 2. DATE AND HOUR OF DEATH Jan 18, 1971 11:15A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines 2525 West Belvedere Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 579 E. 38th Street | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/8/'92 | 9. AGE (In years lost birthday) 78 | If Under 1 Yr. Months: _____ Days: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Goldman & Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Louis Donoba | | | |
| 14. MOTHER'S MAIDEN NAME Helena ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Rita H. Weslow Davis Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral anoxia Generalized DUE TO, OR AS A CONSEQUENCE OF: Possible pulmonary embolus (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 1 hr. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 15 1970 to Jan 18 1971 , that (I) (we) last saw the deceased alive on Jan 12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alan B Cohen | | | | 23B. DATE SIGNED Jan 18, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Alan B Cohen | | | | 23D. ADDRESS 3501 ST Paul ST Balto Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/'71 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE RECD BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF REGISTRAR John A. Moran, Inc. | | 25C. FUNERAL DIRECTOR (Address) 3000 E. Baltimore St. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0580 |
|--|-------------------------|---|-------------------------------------|---|
| CERTIFICATE OF DEATH | | | | REG. NO. _____ |
| BIRTH NO. <u>A-200</u> | | 71 0580 | | |
| 1. NAME OF DECEASED (Type or Print) <u>AQUIA, ANTHONY J.</u> | | 2. DATE AND HOUR OF DEATH <u>JANUARY 17, 1971</u> <u>7:00P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY _____ | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> <u>WILKENS & CATON AVES.</u> <u>BALTIMORE, MARYLAND 21229</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>517 S. WICKHAM RD.</u> | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>09 07 44</u> | 9. AGE (In years last birthday) <u>26</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RIDEMAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL LOCAL UNION #16</u> | | 11. BIRTHPLACE (State or foreign country) <u>SICILY</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 13. FATHER'S NAME <u>SALVATORE AQUIA</u> | | 14. MOTHER'S MAIDEN NAME <u>DORA SANSONE</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-42-3450</u> | | 17. INFORMANT <u>ST AGNES RECORDS</u> ADDRESS <u>WILKENS & CATON AVES.</u> |
| 18. CAUSE OF DEATH <u>373X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE <u>Prob. Endotoxin Shock</u></u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) <u>Gram Neg. Sepsis</u></u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) <u>Lung Abscess</u></u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JANUARY 13, 1971</u> to <u>JANUARY 17, 1971</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JANUARY 17, 1971</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) <u>SALVADOR QUIROZ</u> | | 23D. ADDRESS <u>ST AGNES HOSPITAL CATON & WILKENS AVE</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/21/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR <u>John J. Moran, Inc. 3000 E. Baltimore St.</u> |

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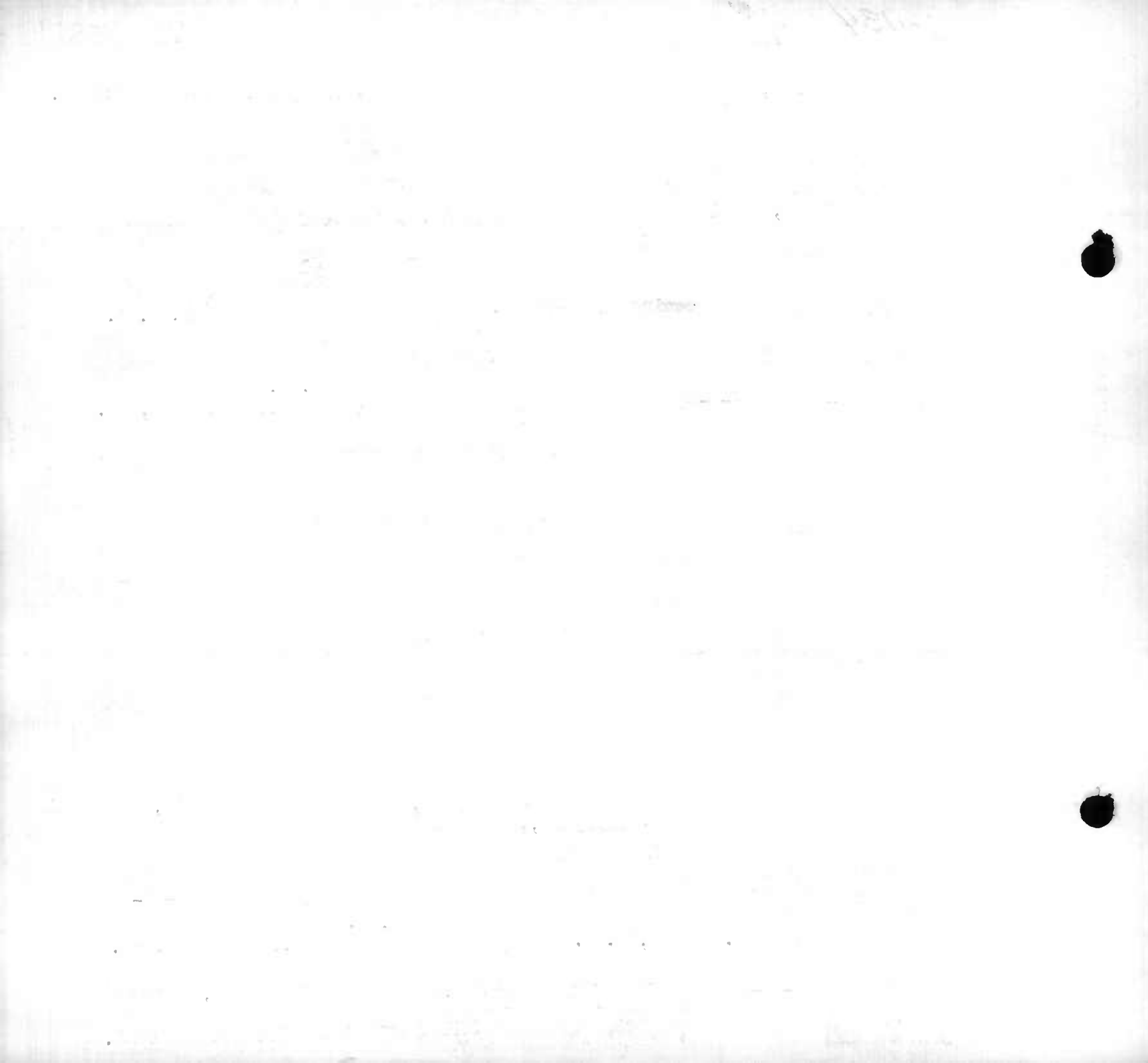
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

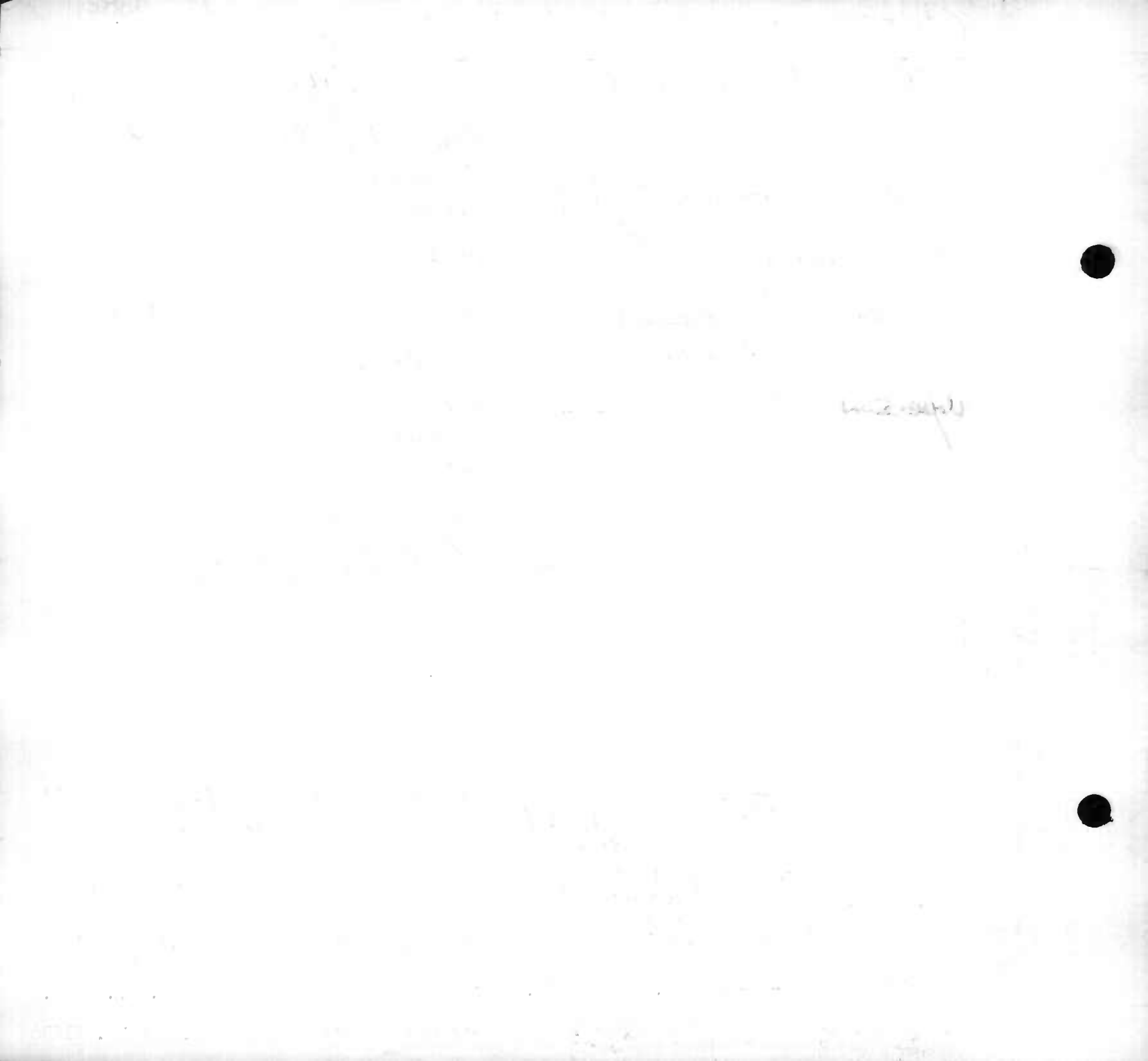
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0581</u> | |
|---|-----------|--|------------------|--|------------------------------|
| C-434 71 0581 | | BIRTH NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| CALDWELL, CHESTER NORMAN | | January 16, 1971 6:20 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland | | Maryland Baltimore | | | |
| 23 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 1917 Jasmine Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months; Days |
| Male | Caucasian | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 5-19-18 | 52 | Hours; Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Aircraft Worker | | Broening Aircraft Co. | | Pennsylvania | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Roland Caldwell | | Julia Miller | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes 12-9-40 to 6-8-45 | | 208 07 03 83 | | Records V. A. Hospital | |
| | | | | 3900 Loch Raven Blvd., Baltimore, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Respiratory arrest | | 35 Minutes | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Chronic Obstructive lung disease | | 4 Years | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | Electrolyte abnormalities | | 1-7 Days | |
| | | (C) | | | |
| II | | Aspiration vomitus | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from January 16, 1971 to January 16, 1971 that (we) last saw the deceased alive on January 16, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| John F. Rogers, M. D. | | 1-16-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | V. A. Hospital | | | |
| | | 3900 Loch Raven Blvd., Baltimore, Md. 21218 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 1-20-71 | | Holly Hill Memorial Gardens | |
| | | | | White Marsh, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 21 1971 | | John F. Rogers, M.D. | | JOHN J. DODA | |
| | | | | 1922 Wise Ave Balto Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

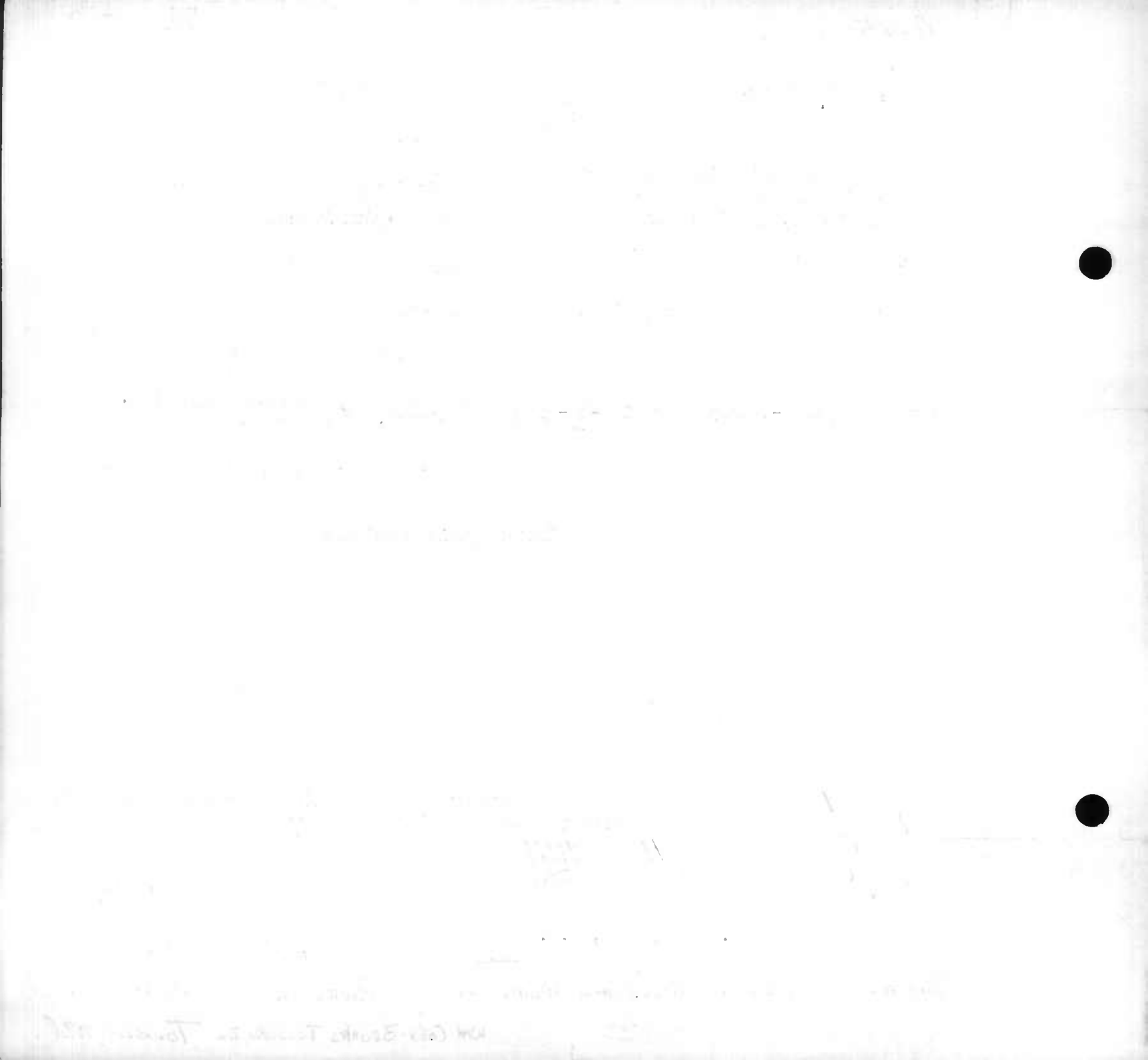
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|---|-------------------------|---|---|---|--|---|--|
| C-552 | | 71 0582 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0582 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Cumming, Benjamin W.</i> | | | | 2. DATE AND HOUR OF DEATH <i>1/16/71 7:30 p.m.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i> | | | | A. STATE <i>Maryland</i> | | B. COUNTY <i>Baltimore</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN <i>Kingsville</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <i>11717 Cedar Lane</i> | | | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>04-21-00</i> | 9. AGE (in years lost birthday) <i>70</i> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Government</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 13. FATHER'S NAME <i>Cumming, Benjamin</i> | | | | |
| 14. MOTHER'S MAIDEN NAME <i>Elizabeth Wolverton</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <i>Yes WW II</i> | | | | |
| 16. SOCIAL SECURITY NO. <i>403-05-8225A</i> | | | 17. INFORMANT <i>Eva Cumming</i> | | | | |
| ADDRESS <i>Same</i> | | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>41231</i> | | | | |
| CAUSE OF DEATH <i>Cardiac arrest</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i> | | | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertrophy of left ventricle</i> | | | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: <i>Old myocardial infarct</i> | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>II</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>1/15</i> 19 <i>71</i> to <i>1/16</i> 19 <i>71</i> that (I) <i>(we)</i> last saw the deceased alive on <i>1/16/71</i> 19 <i>71</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> <i>(did)</i> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>H. Earl Cotman, M.D.</i> | | | | 23B. DATE SIGNED <i>1/16/71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>H. Earl Cotman, M.D.</i> | |
| 23D. ADDRESS <i>Union Memorial Hospital</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1-20-71</i> | | 24C. NAME of CEMETERY or CREMATORY <i>St. Johns Epis. Cemetery</i> | | 24D. LOCATION (City, town, or county) State <i>Kingsville Balto. Co. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Passion Funeral Home 7401 Belair Rd. 21236</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

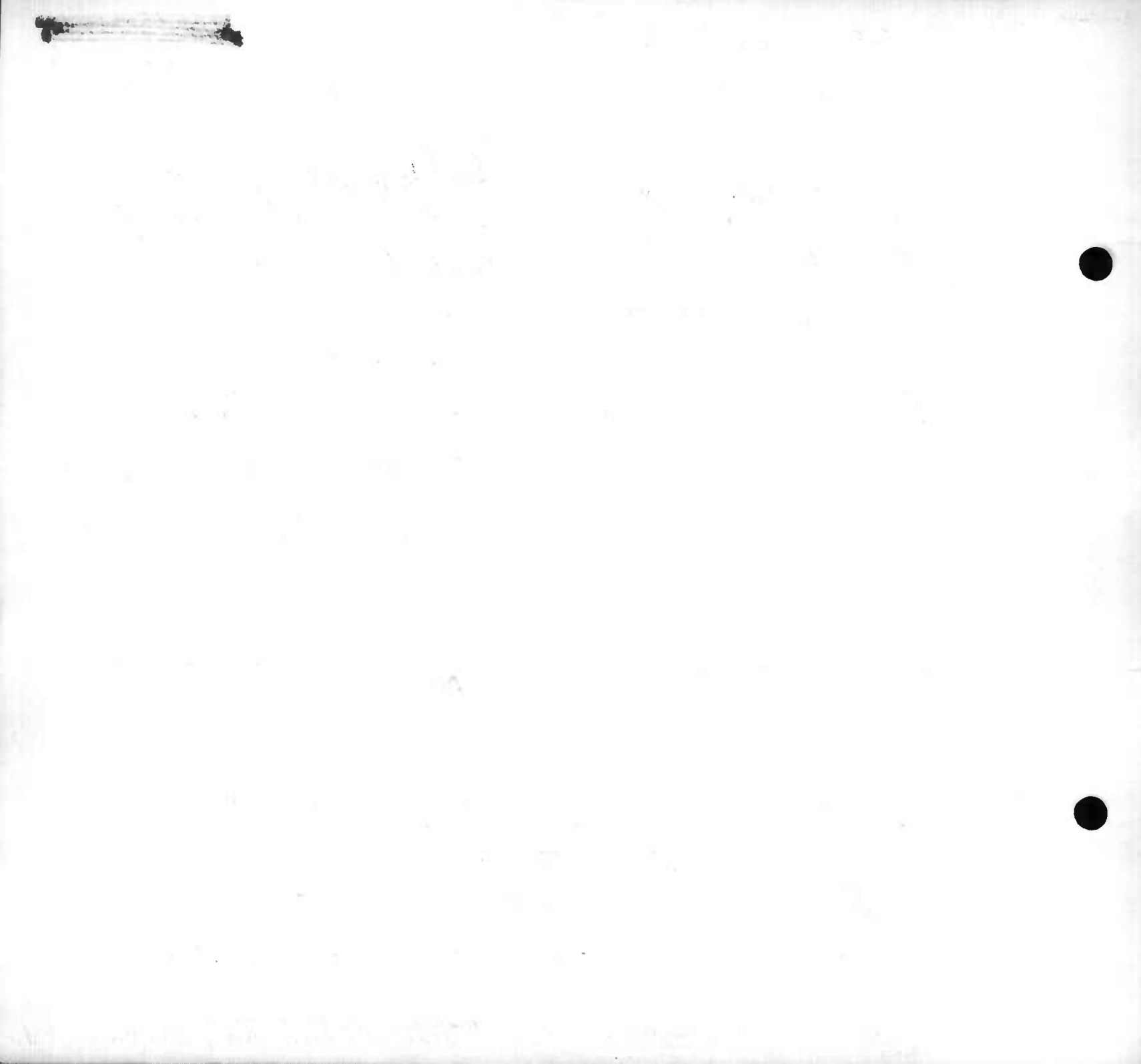
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0583 | |
|--|-----------------------------|---|--|--|---|
| CERTIFICATE OF DEATH | | | | REG. NO. 71 0583 | |
| BIRTH NO. <u>M-450</u> | | 71 0583 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>MULLAN, Joseph Henry</u> | | | 2. DATE AND HOUR OF DEATH <u>1/19/71</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-07</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2817 Hampden Avenue</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/1/13</u> | 9. AGE (in years last birthday) <u>57</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Drug store</u> | 11. BIRTHPLACE (State or foreign country) <u>Cumberland Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>John Mullan</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Eulich</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>9/1/42-7/6/45</u> | | 16. SOCIAL SECURITY NO. <u>217-10-5380</u> | 17. INFORMANT ADDRESS <u>VA Hospital 3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u> | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Thrombo embolism</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Bronchogenic carcinoma</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>January 6th</u> 19 <u>71</u> to <u>January 19th</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>January 19th</u> 19 <u>71</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>William D. Hakkarinen, M.D.</u> | | | | 23B. DATE SIGNED <u>1/19/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>WILLIAM D. HAKKARINEN, M.D.</u> | | | | 23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>1-22-71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u> | | 24D. LOCATION (City, town, or county) (State) <u>Parkville Balt. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talbot</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson, Inc. Towson, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

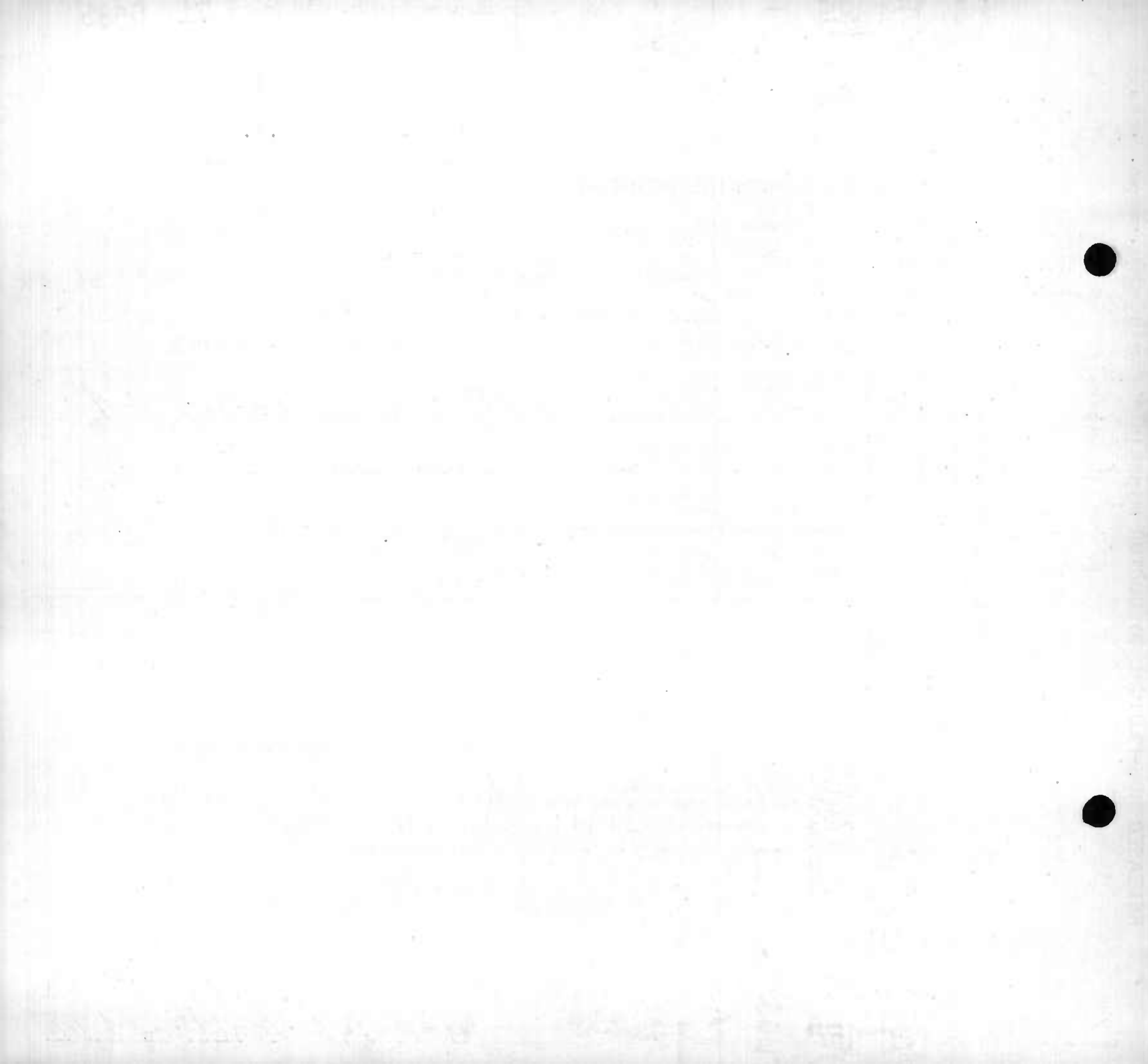
| BIRTH NO. <u>M-236</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0584</u> | | | |
|---|--|----------------------|--|---|--|---------------------------------|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Nicholas Mastomacolis</u> | | | | 2. DATE AND HOUR OF DEATH <u>1/15/71</u> <u>5:40</u> P.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> | | | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u> | | | | A. STATE <u>Md.</u> B. COUNTY <u>26-07</u> | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER <u>700 S. Oldham St. 21224</u> | | | | | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-16-13</u> | | 9. AGE (In years last birthday) <u>57</u> | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Greece</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | 13. FATHER'S NAME <u>Mamuel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Protopapas</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>234-44-9565</u> | | | | 17. INFORMANT ADDRESS <u>4940 Eastern Avenue</u> <u>BCH-Records Baltimore, Maryland 21224</u> | | | |
| 18. <u>4-10-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Anoxia</u> (B) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>6 wks.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | 22. I certify that <u>47</u> (this hospital) attended the deceased from <u>12/6</u> 19 <u>70</u> to <u>1/5</u> 19 <u>71</u> that <u>4</u> (we) last saw the deceased alive on <u>1/5</u> 19 <u>71</u> and that in <u>(we)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Russell Harris</u> | | | | 23B. DATE SIGNED <u>1/15/71</u> | | | | 23C. PHYSICIAN'S NAME (Type) <u>Russell Harris</u> | | | |
| 23D. ADDRESS <u>4940 Eastern Avenue</u> <u>BCH- Baltimore, Maryland 21224</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>1-18-71</u> | | | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u> | | | | 25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u> | | | | ADDRESS <u>3221 Eastern Ave., Baltimore, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0585 | |
|--|--|---|--|---|--|
| D-152 | | 71 0585 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Bernard F. Dobbins</u> | | 2. DATE AND HOUR OF DEATH <u>1/17/71</u> <u>9:05</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>A.A.</u> | | C. CITY OR TOWN <u>ANNAPOLIS</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <u>MALE</u> | | 6. RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>3-13-04</u> | | 9. AGE (In years last birthday) <u>66</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>TWINE + CORDAGE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>BERNARD F. DOBBINS</u> | | 14. MOTHER'S MAIDEN NAME <u>MARGUERITE FLICKINGER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>163057830</u> | | 17. INFORMANT <u>ORENE R. DOBBINS</u> ADDRESS <u>#4</u> | |
| 18. <u>4/10/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Massive 2° heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Heart 2° to ? MI</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8hr</u> <u>10hr</u> <u>6-8hr</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> <u>Massive liver disease = cirrhosis</u> | | 19A. DATE OF OPERATION <u>1/17/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Porto-caval Shunt</u> | |
| 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> 19 <u>71</u> to <u>1/17</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <u>William I. Anderson</u> | | 23B. DATE SIGNED <u>1/17/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>William I. Anderson</u> | | 23D. ADDRESS <u>Johns Hopkins Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 24B. DATE <u>1-19-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Ft. Lincoln</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BLADENSBURG P.G. MD.</u> | | 25A. DATE RECD BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>John M. Anderson</u> | |
| 25C. FUNERAL DIRECTOR <u>John M. Anderson</u> | | ADDRESS <u>John M. Anderson</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0586 |
|---|--|---|--|--|
| R-26271-01424 0586 | | | | REG. NO. |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH |
| | | BABY BOY ROGERS | | 1-19-1970 10.21P M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | |
| THE JOHNS HOPKINS HOSPITAL 33 | | MARYLAND A.A. | | |
| | | C. CITY OR TOWN | D. INSIDE CITY LIMITS? | |
| | | GLEN BURNIE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | |
| | | 200 SHANA ROAD | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-17-1971 | ----- |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| | | | St. Agnes Hospital | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| KENNETH ROGERS | | KATHERINE SWEENEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 24 hrs |
| | | (B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: | | 3 days |
| | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Congenital cardiac disease | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | yes | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/19 to 1/19 1971 that (I) (we) last saw the deceased alive on 1/19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | |
| Dianne S. Elfenbein | | Jan 20, 1971 | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| DIANNE S. ELFENBEIN | | THE JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | |
| Cremation | 1/20/71 | Johns Hopkins Hospital | 601 N Broadway Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | HOSPITAL DISPOSAL | |
| JAN 21 1971 | Robert E. Volpert | | | |



H-400

71 0587

BALTIMORE CITY HEALTH DEPARTMENT

71 0587

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) BERNARD ALFRED HILL | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 19 1971 8:40 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 235 N. Dallas Ct. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 19 1971 8:40 P.M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN B'to. | |
| 9. DATE OF BIRTH 8/31/11 | | 10. AGE (In years last birthday) 59 | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? Columbus Hill | |
| 13. FATHER'S NAME SARAH Dorsey | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SARAH Hill 235 N. Dallas Ct. | |
| 15. MOTHER'S MAIDEN NAME SARAH Hill 235 N. Dallas Ct. | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT SARAH Hill 235 N. Dallas Ct. | |
| 19. CAUSE OF DEATH 4-12-81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-20-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/23/71 | |
| 24C. NAME OF CEMETERY or CREMATORY mt. Calvary | | 24D. LOCATION (City, town, or county) (State) D. D. County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. J. [illegible] | |
| 25C. FUNERAL DIRECTOR Joseph H. Locks | | ADDRESS 13042 Capital Ave | |

7880

7880

on 10/10/10 10:10 AM

8-20071

0588

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0588

| | | | |
|--|--|--|--|
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Edith Dock | | DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 303 N. Arlington Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 71 2:10 p.m. | |
| 6. SEX female | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 20-04 | |
| 7. RACE colored | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER 2542 W. Pratt St. | |
| 9. DATE OF BIRTH 3-30-1926 | | 10. AGE (In years last birthday) 44 | |
| 11. BIRTHPLACE (State or foreign country) Durham, North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charlie Tapp | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse | |
| 15. MOTHER'S MAIDEN NAME Cynthia Tapp | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. | |
| 17. SOCIAL SECURITY NO. 243-32-0182 | | 18. INFORMANT ADDRESS Miss Claudia Dock 2542 W. Pratt Street | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner 1/18/71 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-24-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Beach Wood Cemetery | | 24D. LOCATION (City, town, or county) (State) Durham, North Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR [Signature] | |
| 25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street | | | |

8520 11

ALABAMA DEPARTMENT OF REVENUE

STATE OF ALABAMA

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER

MOBILE, ALABAMA

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

YELLOW PAPER

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RANDOLPH DUDLEY

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

5-10-1916

10. AGE (In years
lost birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Caroline Co., Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Md.

B. COUNTY

8-05

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1663 Darley Ave.

13. FATHER'S NAME

Silas Dudley

15. MOTHER'S MAIDEN NAME

Fannie Dudley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

1/13/44

6/27/44

17. SOCIAL
SECURITY NO.

579-10-5864

18. INFORMANT

Mrs. Gertrude Dudley

ADDRESS

1663 Darley Avenue

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)CAUSE OF DEATH
Arteriosclerotic cardiovascular diseaseAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-23-71

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

ADDRESS

1701 Laurens Street

11 0000

WILLIAM S. WALKER, JR. DEPT. 10

21150 100000

21150 100000

21150 100000

21150 100000

WILLIAM S. WALKER, JR. DEPT. 10

WILLIAM S. WALKER, JR. DEPT. 10

WILLIAM S. WALKER, JR. DEPT. 10

WILLIAM S. WALKER, JR. DEPT. 10

WILLIAM S. WALKER, JR. DEPT. 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 0590</u> | |
|--|------------------|---|---|--|--|--|--|
| BIRTH NO. <u>1-520</u> | | 71 0590 | | DATE AND HOUR OF DEATH <u>1-19-71</u> | | 9:05 P.M. | |
| 1. NAME OF DECEASED (Type or Print) <u>Jones, Deborah (Deborah)</u> | | | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u> <u>730 Ashburton Street. Baltimore M.D. 21216</u> | | | | A. STATE <u>MD</u> | | B. COUNTY <u>15-09</u> | |
| | | | | C. CITY OR TOWN <u>Balto</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>2308 Lyndhurst Ave</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-11-51</u> | 9. AGE (In years last birthday) <u>19</u> | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Coppin State College</u> | | 11. BIRTHPLACE (State or foreign country) <u>N.C. Greenville</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Rudolph Jones</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clarice Jones</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u> | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT ADDRESS <u>Mr. Rudolph Jones 2308 Lyndhurst Ave</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>IntraVentricular hemorrhage.</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-18-71</u> to <u>1-19-71</u> and that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Ragunathan Rao</u> | | | | 23B. DATE SIGNED <u>1-19-71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>R. GOVINDA RAO</u> | | | | 23D. ADDRESS <u>Lutheran Hospital of Maryland</u> <u>730 Ashburton Street. M.D. 21216</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/23/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Morton S. Dyck F.H.</u> | | ADDRESS <u>1701 Laurens St.</u> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0591

BIRTH NO.

| | | | | | | | |
|--|--|--|--|---|------|---|--------|
| 1. NAME OF DECEASED (Type or Print) Katie Matthews (Duncan) | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street or institution) 2311 Druid Hill Ave. | | 3. DATE PRONOUNCED DEAD Month | | Day | Year | Hour | M. |
| | | | | 1 | 18 | 71 | 5:40 p |
| 6. SEX female | | 7. RACE colored | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 8-7-1905 | | 10. AGE (In years last birthday) 65 | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 12. CITIZEN OF U.S.A. | | 13. FATHER'S NAME Fred Babney | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 15. MOTHER'S MAIDEN NAME Bessie Williams Nelson | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 17. SOCIAL SECURITY NO. 212-26-3859 | | 18. INFORMANT Mrs. Sallie Williams | | ADDRESS 2405 Francis Street | |

| | | |
|---|---|--|
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Diabetes mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | |
| 20A. DATE OF OPERATION | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21. AUTOPSY? (Yes or No) no |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 22F. HOW DID INJURY OCCUR? |

| | | | |
|---|--|---|--|
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 1/19/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1-22-71 | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | 25B. NAME OF REGISTRAR Robert E. [illegible] | 25C. FUNERAL DIRECTOR MORTON & DYETT F.H. | ADDRESS 1701 Laurens Street |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--------------------|---|--|---|---|--|---------------------------------|--|--|
| 71 0592 | | | | | 71 0592 | | | | |
| BIRTH NO. 7-460 | | | | | REG. NO. 71 0592 | | | | |
| 1. NAME OF DECEASED (Type in Print) MR. ALBERT TAYLOR | | | | | 2. DATE AND HOUR OF DEATH 1/19/71 AT 1:30 A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. CITY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1023 BENNETT PLAZE, BALT. 21223 | | | | |
| 5. SEX MALE | 6. RACE COLORED | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-14-1902 | 9. AGE (In years last birthday) 68 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLER | | | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME P. unk | | | | |
| 14. MOTHER'S MAIDEN NAME P. unk | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. P. | | 16. SOCIAL SECURITY NO. 215 140709 | | 17. INFORMANT LUCILLE TAYLOR | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA CEREBRAL INJURY | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) CEREBRAL INJURY (C) EMPHYSEMA, A.S.H.D. | | | | | 6 DAYS | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II AS MENTIONED IN (C) | | | | | | | | | |
| 21A. DATE OF OPERATION 2 | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED, BREATHING DIFFICULTY | | 21C. AUTOPSY? (Yes or No) No | | 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 3-01 | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET 5 | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 721 S. CAROLINE ST., BALT. | | | | | |
| 21D. TIME OF INJURY (Approx.) 1 13 21 9A | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? FELL ON ICE AND INJURED HIS HEAD | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/13 to 1/19 1971 and that (I) (we) last saw the deceased alive on 1/13/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE N. UMRAN, M.D. | | | | | 23B. DATE SIGNED 1/19/71 | | | 23C. PHYSICIAN'S NAME (Type) N. UMRAN, M.D. | |
| 23D. ADDRESS CHURCH HOME & HOSP. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Morton S. Dyett F.H. 1701 Laurens St | | | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

Jane S. Wilmer

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
1Day
17Year
71Hour
6:45 p.

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 4206 Roland Ave.- Apt. 1D

3. DATE
PRONOUNCED DEADMonth
1Day
17Year
71Hour
6:45 p.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 27-14

6. SEX

female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

August 8, 1914

10. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4206 Roland Avenue - Apt. 1D

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Roger Lee Shivers

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

Own Home

15. MOTHER'S MAIDEN NAME

Jane Tohr

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

215-07-6141

18. INFORMANT

8325 S. W. 72nd Ave.
Henry Edwin Wilmer South Miami, Fla.

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Exsanguination due to laceration on chin

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB.
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

HOME

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4206 Rolland Ave.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

1

17

71

unk

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Deceased apparently fell.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/18/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/20/71

24C. NAME of CEMETERY or CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore,

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

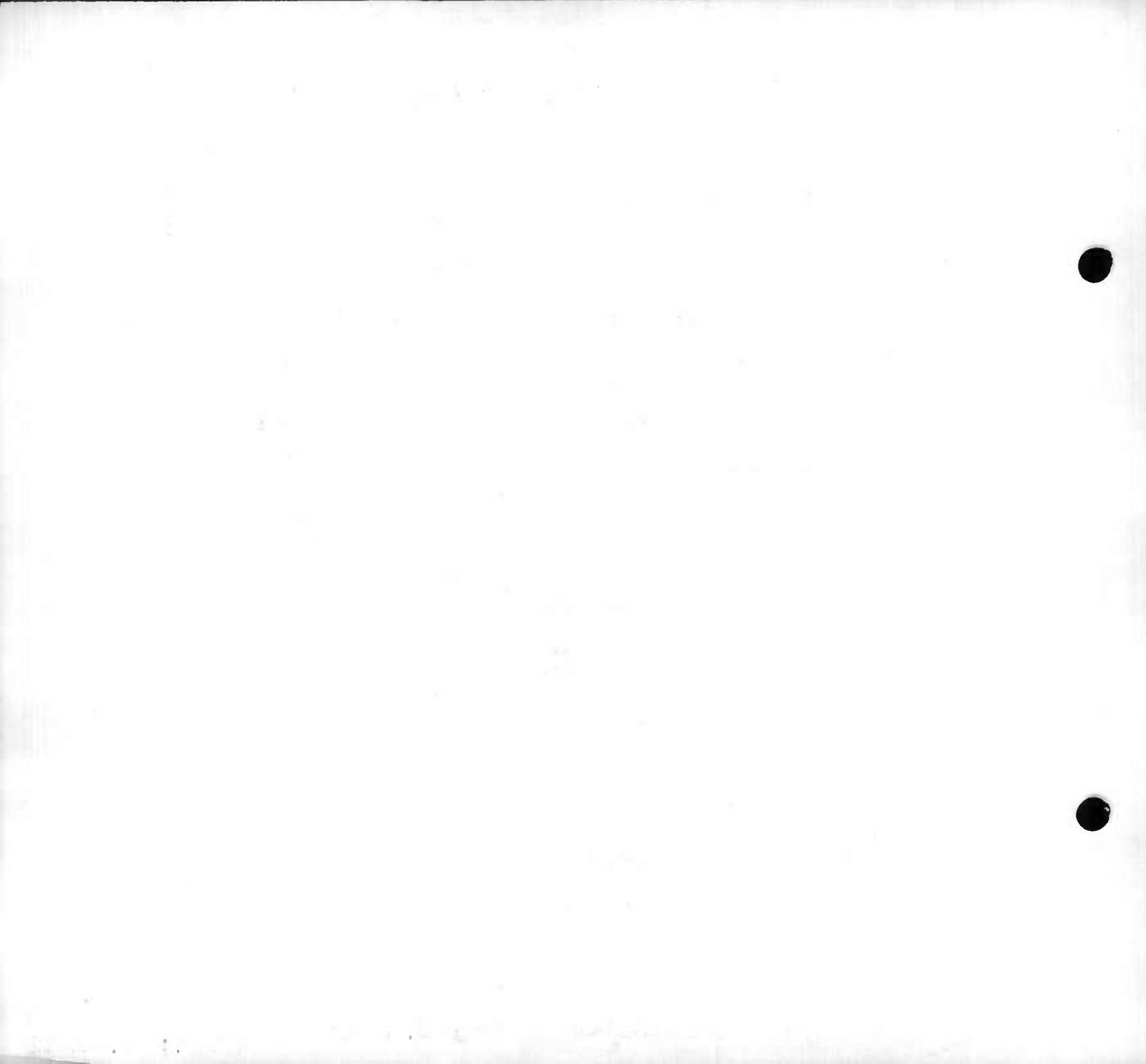
ADDRESS

Balto., Md. 21212

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0594 | |
|---|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 71 0594 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Gemmell, Mary Clark | | 2. DATE AND HOUR OF DEATH 1/20/71 19:00 a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hosp | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 101 W. Monument Street | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 09-12-95 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY INSURANCE | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOHN E. CLARK | | | |
| 14. MOTHER'S MAIDEN NAME SARAH BURKE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 220-12-2946 | | 17. INFORMANT MRS. M. ROCK KIEFER | | | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) Arterio-sclerotic cardio-vascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE HEART FAILURE CHRONIC OBSTRUCTIVE | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: PULMONARY DISEASE | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/16/71 to 1/20/71 that (I) (we) last saw the deceased alive on 1/20/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE H. EARL COTMAN, M.D. | | 23B. DATE SIGNED 1/20/71 | | 23C. PHYSICIAN'S NAME (Type) H. EARL COTMAN, M.D. | |
| 23D. ADDRESS Union Memorial Hosp. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 1/22/71 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Henry B. Jenkins | | 25C. FUNERAL DIRECTOR Henry B. Jenkins & Sons Co. | |
| 25D. ADDRESS Balto., Md. 21212 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

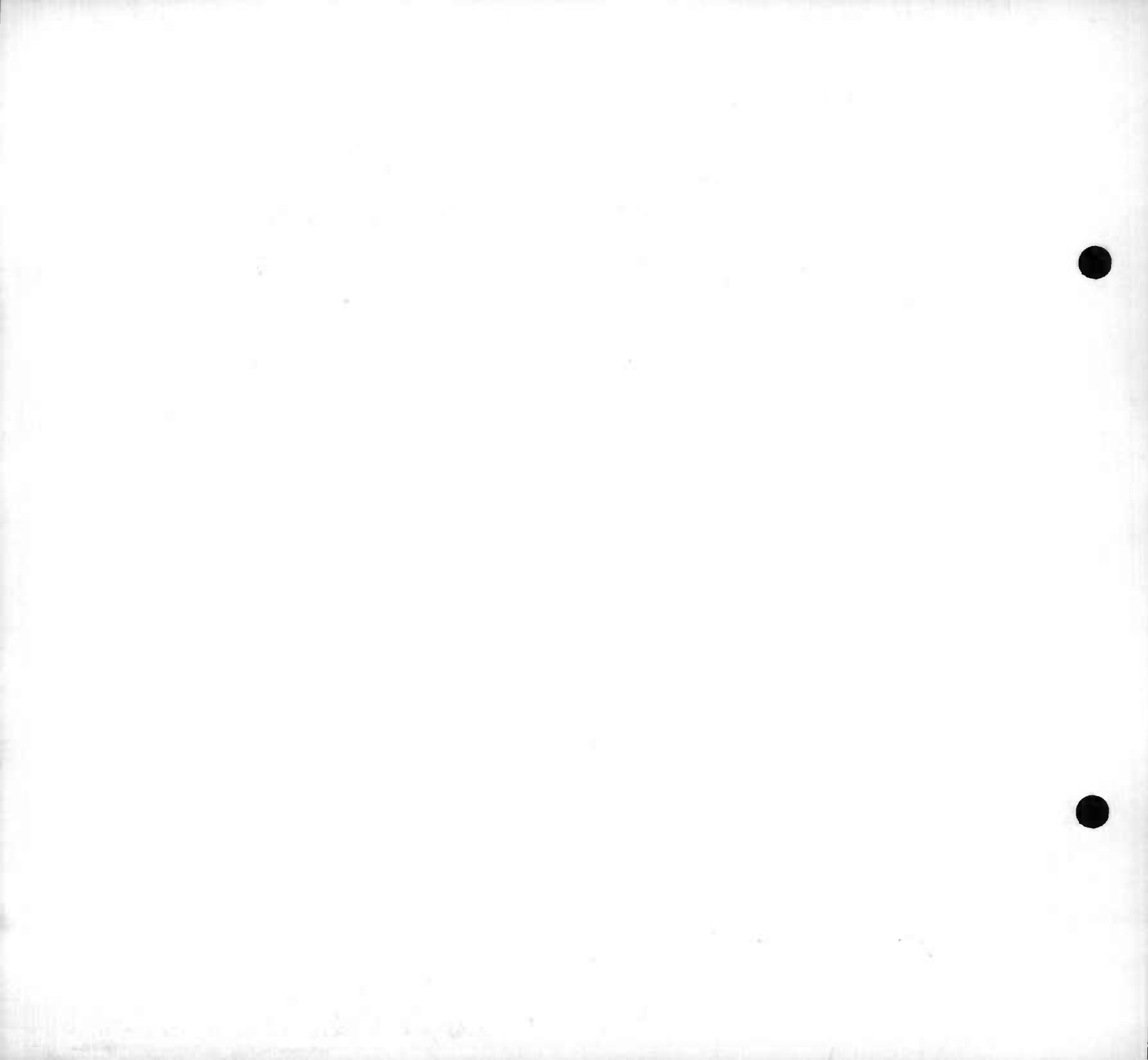
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0595 | |
|---|--|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 71 0595 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Elizabeth S. Phillips | | | 2. DATE AND HOUR OF DEATH Jan. 19, 1971 5:00 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1501 Gorsuch Avenue | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX F 6. RACE W | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH 4-11-1880 | | 9. AGE (In years last birthday) 90 | | If Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Buffalo, New York | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Theodore Schenning | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | |
| 16. SOCIAL SECURITY NO. 220-44-6703 | | 17. INFORMANT ADDRESS Mrs. Laura Parr 1501 Gorsuch Ave. | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) art rel cv disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) none | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/7 19 67 to 1/19 71 that (I) (we) last saw the deceased alive on 1/19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Maurice Feldman | | | 23B. DATE SIGNED 1/19/71 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Maurice Feldman, Jr. | | | 23D. ADDRESS 6610 Cross Country Blvd. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-22-1971 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | |
| | | | | ADDRESS 4905 York Road Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0596</u> | |
|---|--------------------|---|---------------------------------|---|--|
| 71 0596 | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| <u>Schontz, Isabelle</u> | | <u>1-13-71</u> | | <u>8:30 P. M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Dukeland Nursing Home - 1501 N. Dukeland St.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Prince Georges</u> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Hyattsville</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>313 Dupont St.</u> | | <u>17-02</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>N N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-31-81</u> | 9. AGE (in years last birthday) <u>89</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| <u>Housewife</u> | | | | <u>Unknown U.S.A.</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| | | <u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>218-58-2509</u> | | 17. INFORMANT ADDRESS <u>1501 N. Dukeland St.</u> | |
| | | | | | |
| 18. <u>440.9 I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE <u>Atherosclerosis</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-28-1966</u> to <u>1-13-1971</u> that (I) (we) last saw the deceased alive on <u>1-12-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Percival C. Smith</u> | | 23B. DATE SIGNED <u>1-15-71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Percival C. Smith</u> | | 23D. ADDRESS <u>Dukeland Nursing Home</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1/20/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u> | |
| <u>Burial</u> | | | | <u>Baltimore</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>100</u> | | 25C. FUNERAL DIRECTOR <u>Joseph H. Hines</u> | |
| | | | | ADDRESS <u>2222 W. North Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0597 | |
|--|--|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Watson, Pearl G. Blake</i> | | 2. DATE AND HOUR OF DEATH <i>1-14-71 9:25 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>15-02</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Mt. Sinai Nursing Home 4613 Park Heights Ave.</i> | | | C. CITY OR TOWN <i>Baltimore</i> 17 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <i>F</i> 6. RACE <i>Blk</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <i>10-24-03</i> | | 9. AGE (in years last birthday) <i>67</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> |
| 13. FATHER'S NAME <i>John A. Fitch</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mattie Lou Robinson</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mr. Lemuel Blake</i> ADDRESS <i>2506 Edmont St</i> |
| 18. <i>153.81</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH <i>Carcinoma of Colon</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic to lung</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>None</i> (C) <i>None</i> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Nov 5 1970</i> to <i>Jan 14 1971</i> that (I) (we) last saw the deceased alive on <i>Jan 14 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Manuel Levin</i> | | | | 23B. DATE SIGNED <i>1/18/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN MD</i> | | | | 23D. ADDRESS <i>6101 PARK HILLS AVE BALTO - 15 Md</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>1/18/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Carver Mem. Park</i> | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (City, town, or county) | | 24F. LOCATION (City, town, or county) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1971</i> | | 25B. NAME OF REGISTRAR <i>Ed E. Taylor, R.D.</i> | | 25C. FUNERAL DIRECTOR <i>Joseph P. Harris</i> ADDRESS <i>2222 W. North Ave.</i> | |

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0598

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) THOMAS BROWN | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Armco Steel 2501 E. Biddle St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 19 1971 1:25 P.M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH Sept. 5, 1911 | | 10. AGE (in years last birthday) 59 | |
| 11. BIRTHPLACE (State or foreign country) King William Co., Va. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Walter Brown | | 14. MOTHER'S MAIDEN NAME Myrtle Lee | |
| 15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-06 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 228-10-2633 | |
| 18. INFORMANT Mrs. Margaret Brown | | ADDRESS 3017 Herbert St. | |
| 19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-20-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Buried | | 24B. DATE Jan. 1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Bethany Bapt. Ch. Conv. | | 24D. LOCATION (City, town, or county) (State) King William Co., Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Joseph L. Davis | | ADDRESS 2222 W. North Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0599 | |
|--|--|--|--|--|--|
| BIRTH NO. 71 0599 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Clara E. Roston | | 2. DATE AND HOUR OF DEATH Jan 12, 1971 1530 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 25-62 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2701 Carver Road | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 2701 Carver Rd. | | | |
| 5. SEX Female | 6. RACE Caucas | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 24, 1895 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Smithville B., Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Edward Masley | | 14. MOTHER'S MAIDEN NAME Eliza Masley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 035-22-4265 | | 17. INFORMANT Mrs. Margaret Harris | |
| 18. 4-10-9 H-25019 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCT | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC C-V-DIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DIABETES MELLITUS | | (C) ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 10/2/1969 to 1/12/1971 and that (1) (we) last saw the deceased alive on 1/11/1971 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John S. Braxton Jr. | | 23B. DATE SIGNED 1/18/71 | | 23C. PHYSICIAN'S NAME (Type) JOHN S. BRAXTON JR. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/18/71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Conv. | |
| 24D. LOCATION Baltimore | | 24E. NAME OF REGISTRAR Robert E. Talbot, Md. | | 24F. FUNERAL DIRECTOR Joseph P. Gues | |
| 24G. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 24H. NAME OF REGISTRAR Robert E. Talbot, Md. | | 24I. ADDRESS 2222 W. North Ave | |



CERTIFICATE OF DEATH

REG. NO.

71 0600

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

IRVIN ADAMS C.

2. DATE AND HOUR OF DEATH

19 JAN 1971

6 20

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

125 Balnew Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11/19/88

9. AGE (In years
last birthday)

82

If Under 1 Yr.
Months: Days: Hours: Min.If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Adams

14. MOTHER'S MAIDEN NAME

Emma Smith

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Clarence Adams

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

1) PANHYPOTITUARISM

2) DIABETES MELLITUS

(B)

DUE TO, OR AS A CONSEQUENCE OF:

3) METASTATIC PROSTATIC CA.

(C)

4) ARTERIO-SCLEROTIC atherosclerosis

+ gangrene

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

INSTANTANEOUS

3 YEARS

2 MOS.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

NA

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 DEC 19 70 to 19 JAN 19 71.
that (I) (we) last saw the deceased alive on 19 JAN 6 34 AM 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Herbert B. Allen, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

19 JAN 1971

23C. PHYSICIAN'S
NAME (Typed)

Herbert B. Allen, M.D.

23D. ADDRESS

Johns Hopkins Hospital, Baltimore

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-22-71

24C. NAME OF CEMETERY or CREMATORY

Catholics Cont

24D. LOCATION

Catholics Cont

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Edwin J. Brown, M.D.

ADDRESS

A-3551

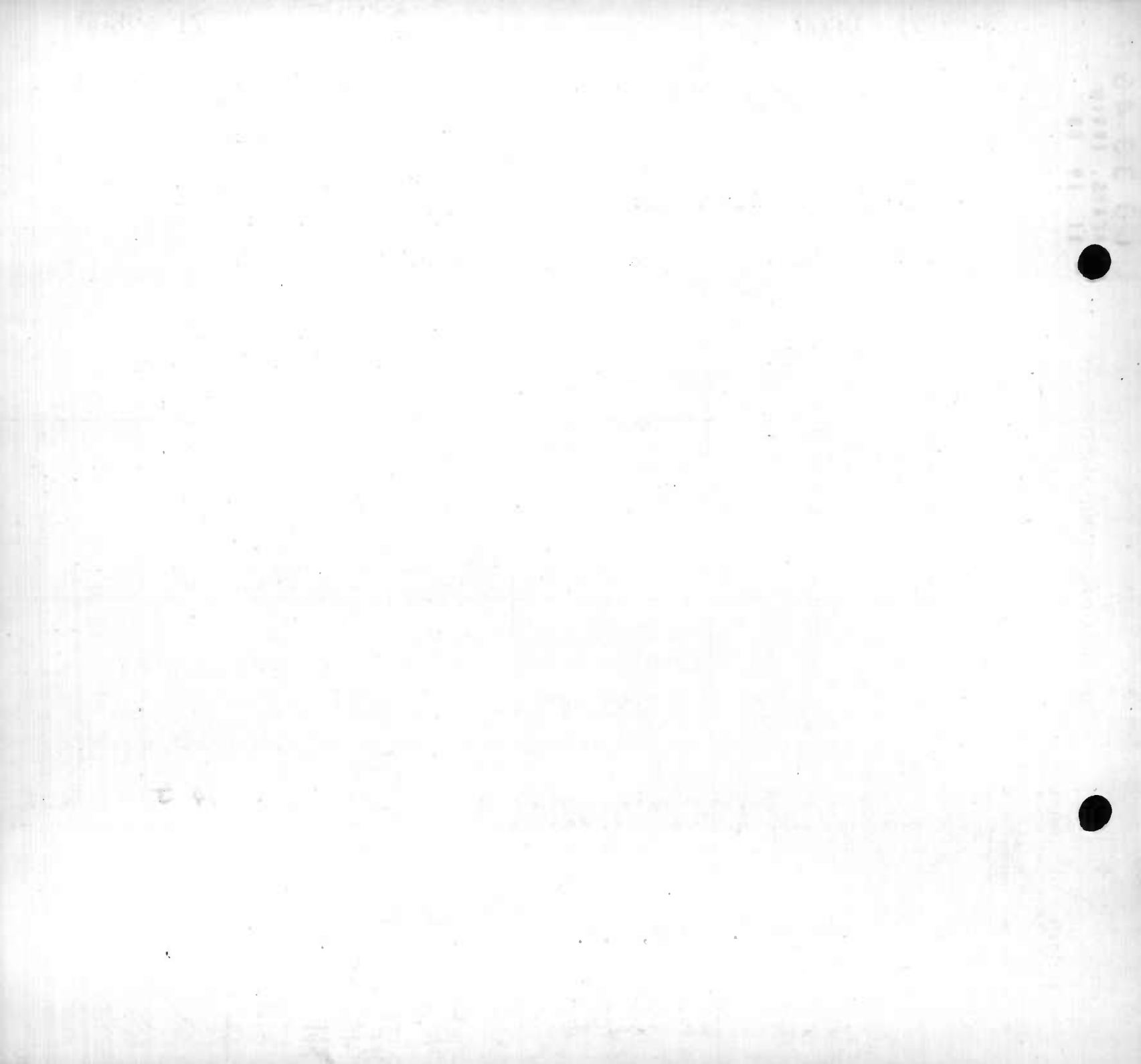
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11 19 88

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



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71 0601

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0601

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) WILLIAM WISE | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 15 1971 1:15 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 837 Mc Aleer Court | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 15 1971 1:15 P.M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH June 1, 1903 | | 10. AGE (In years last birthday) 56 | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Wise | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cause foodw | |
| 15. MOTHER'S MAIDEN NAME Josephine Gross | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, dates of service) No | |
| 17. SOCIAL SECURITY NO. 41-2-21 | | 18. INFORMANT Josephine Gross 1117 Calumet St | |
| 19. CAUSE OF DEATH Hypertensive cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 1-18-71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-16-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-18-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Not known | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Condon, on Brantly | | ADDRESS | |

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BALTIMORE CITY HEALTH DEPARTMENT

71 0602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0602

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) DANIEL DAVIS | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 17 North Caroline Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 11, 1971 11:00 A.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 9-12-1892 | | 10. AGE (In years lost birthday) 78 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Mrs. Pearl H. Smith | | ADDRESS | |
| 19. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/11/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-16-71 | |
| 24C. NAME OF CEMETERY or CREMATORY MT CALVARY | | 24D. LOCATION (City, town, or county) (State) ARUNDEL Co MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Talley, M.D. | |
| 25C. FUNERAL DIRECTOR Edgar Wilson | | ADDRESS 1000 BRANTLEY AVE | |

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FUNERAL DIRECTOR: IMPORTANT

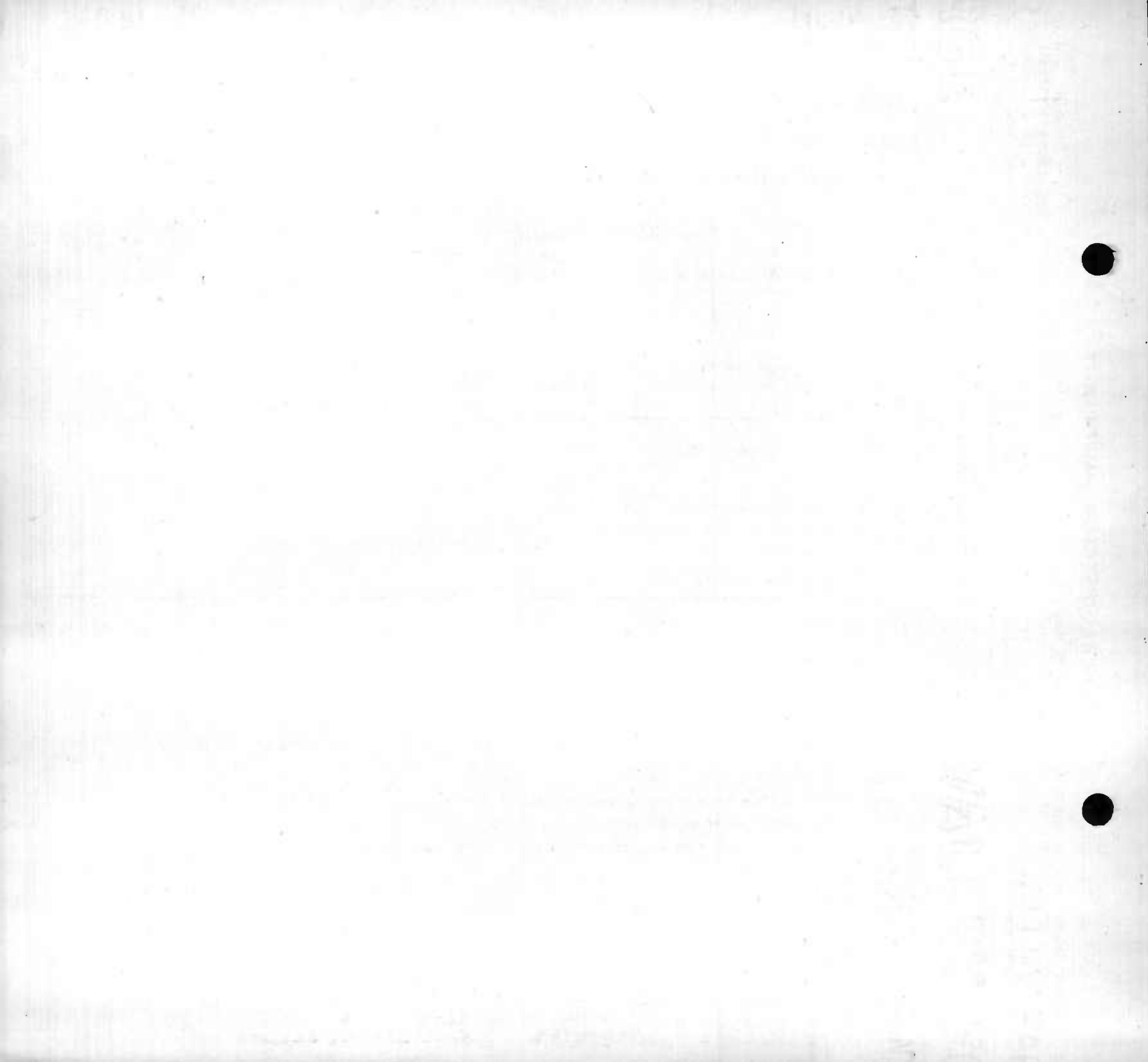
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0603 | |
|---|--|---|--|--|---|
| BIRTH NO. 71 0603 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mabel Chappell | | | 2. DATE AND HOUR OF DEATH 1/15/71 145 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 9-08 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) George Washington Nurs. Home | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Female 6. RACE Non-white | | | E. STREET AND NUMBER 2315 Robt Street | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | B. DATE OF BIRTH 10-1-04 9. AGE (In years last birthday) 66 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Nick HARRIS | | | 14. MOTHER'S MAIDEN NAME ELIZA JACKSON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 214-12-0476 | | 17. INFORMANT CHART # 975 ADDRESS 607 PENNA AVE |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 250.91 Generalized Arteriosclerosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Pyelonephritis (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 10-2-70 to 1-15-71 , that (1) (we) last saw the deceased alive on 12-18-70 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard L. Tyson M.D. | | | | 23B. DATE SIGNED 1-15-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Richard Tyson M.D. | | | | 23D. ADDRESS 936 W. North Avenue Balto. Md. 21217 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1-19-71 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cent | |
| 24D. LOCATION (City, town, or county) (State) A A County Md | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR E. Lloyd O. Nelson | | ADDRESS 343 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0604 | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) JORDAN HARDING | | 2. DATE AND HOUR OF DEATH 740 PM 1/15/71 7.40 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY 8-08 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33 | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1049 N. DURHAM STREET | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-26-25 | 9. AGE (In years lost birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Employee | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Woodrow Brantley | |
| 18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain stem stroke | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Brain stem stroke (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GI Bleed | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/19/70 to 1/15/71 , that (I) (we) last saw the deceased alive on 1/15/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Henry D. Dearborn Ziegler, MD DEGREE | | | | 23B. DATE SIGNED 1/15/71 | |
| 23C. PHYSICIAN'S NAME (Type) Henry Dearborn Ziegler, MD DEGREE | | | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-19-71 | | 24C. NAME OF CEMETERY or CREMATORY Care Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Frederick, MD | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber, R.D. | | 25C. FUNERAL DIRECTOR Woodrow Brantley Jr ADDRESS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>343356</u> |
|--|---|---|--|---|
| CERTIFICATE OF DEATH | | | | <u>71 0605</u> |
| BIRTH NO. <u>71 0605</u> | | 1. NAME OF DECEASED (Type or Print) <u>MADE, Ralph</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH <u>11/17/71</u> <u>1:30 PM</u> M. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MCM</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>16-07</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER <u>1203 N. Longwood St</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-28-1914</u> | 9. AGE (in years last birthday) <u>56</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>James H. Wade</u> | | 14. MOTHER'S MAIDEN NAME <u>Carrie Cross</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-226847</u> | 17. INFORMANT <u>Face sheet</u> ADDRESS | |
| 18. <u>43191</u> CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CVA (Hemorrhage)</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-9-71</u> to <u>1-17-71</u> that (I) (we) last saw the deceased alive on <u>1-17-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>M. J. Wade</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>11/17/71</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>MADE, Ralph</u> | | 23D. ADDRESS <u>MCM</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>1-21-71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u> | 25C. FUNERAL DIRECTOR <u>E. Roy O. Wilson</u> ADDRESS <u>21st</u> | | |



71 0606 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0606

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MILDRED BROWN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 19 1971 12:15 P.M. | |
| 6. SEX female | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 8-06 | |
| 9. DATE OF BIRTH 1-6-1934 | | 10. AGE (In years lost birthday) 36 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Alice Easter | | ADDRESS | |
| 19. 431.9 i CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-23-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cat | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Faber, M.D. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS 1000 Pimlico | |

100

100

100



| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) David Cramer | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital ADDRESS OR LOCATION 3-10-71 | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 19 71 9:12 a M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 71-03 | |
| 9. DATE OF BIRTH 9/15/1923 | | 10. AGE (in years lost birthday) 47 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME David Cramer | | 14. MOTHER'S MAIDEN NAME Susan Cordell | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | 16. KIND OF BUSINESS OR INDUSTRY Construction Co. | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | 18. SOCIAL SECURITY NO. 216-14-5205 | |
| 19. CAUSE OF DEATH E-8841X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ruptured Berry Aneurysm Arteriosclerotic cardiovascular disease | | 19. CAUSE OF DEATH Craniocerebral injury (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerotic cardiovascular disease | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Industrial Park | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Lark Brown Rd., Columbia, Md. | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 1 19 71 7:40 a.m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? fell approx. 18' to floor | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 1/19/71 DATE SIGNED | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Rose Hill Cem. | | 24D. LOCATION (City, town, or county) (State) Hagerstown Wash. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Gabe | |
| 25C. FUNERAL DIRECTOR Robert E. Gabe | | 25D. ADDRESS Hagerstown, Md. | |

Letter from M.E.'s office

3-10-71

M.H.

P-543

71 0608

BALTIMORE CITY HEALTH DEPARTMENT

71 0608

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) INEZ V. REYNOLDS | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 21, 1971 6:20 A. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1602 Aliceanne Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 21, 1971 6:20 A. | |
| 6. SEX Female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH Sept. 18, 1907 | | 10. AGE (In years last birthday) 63 | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 234-22-6645 | |
| 18. INFORMANT Ruby Fauble - 1602 Aliceanna St. #21231 | | ADDRESS Ruby Fauble - 1602 Aliceanna St. #21231 | |
| 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) No | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED January 21, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | |
| 24C. NAME OF CEMETERY or CREMATORY Greenhill Cemetery | | 24D. LOCATION (City, town, or county) (State) Berryville, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Fauble, M.D. | |
| 25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231 | | ADDRESS George A. Weber - 705 S. Ann St. #21231 | |

8830 N

8830

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1911

Dear Sir:

7

Very respectfully,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

VALLEY PAPERS

ACADEMIC RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0609 | |
|--|---|---|--|---|--|
| BIRTH NO. M-424 | | 71 0609 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) CATHERINE MILCHLING | | | 2. DATE AND HOUR OF DEATH January 19 1971 1 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY 26-41 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER 44 | | | F. PINE RIDGE NURSING HOME 4307 HAMPNETT AVENUE | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-19-91 | 9. AGE (In years last birthday) 79 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - CLERK | | | 10B. KIND OF BUSINESS OR INDUSTRY DEPT. STORE | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | |
| 13. FATHER'S NAME UNKNOWN CHRISTIAN MILCHLING | | | 14. MOTHER'S MAIDEN NAME UNKNOWN ELIZABETH STENGLEIN | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Mrs. Lehmer - 4909 Hamilton Ave. |
| 18. CAUSE OF DEATH 56031423010 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | HYPOVOLEMIC SHOCK hours |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) INTESTINAL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF: | | days |
| (C) FECAL IMPACTION | | | | | days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETIC ACIDOSIS | | | | | days |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 1971 to January 19 1971 that (I) (we) last saw the deceased alive on January 19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cesar A Bravo | | | 23B. DATE SIGNED 1/19/71 | | |
| 23C. PHYSICIAN'S NAME (Type) CESAR A BRAVO | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-22-71 | | 24C. NAME OF CEMETERY or CREMATORY JERUSALEM LUTH. Cem. | |
| 24D. LOCATION BALTO. MD. | | 24E. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 24F. NAME OF REGISTRAR Dorothy Miller | |
| 24G. ADDRESS 2334 Jefferson St. | | 24H. NAME OF REGISTRAR Dorothy Miller | | 24I. ADDRESS 2334 Jefferson St. | |

Washington July - 1 - 1968

4909 Hamilton St.

NON-MED CASE: per Dr. Spitz, M.D. QK Smolewicz

FUNERAL DIRECTOR: IMPORTANT!! 1071

GEN REC RM

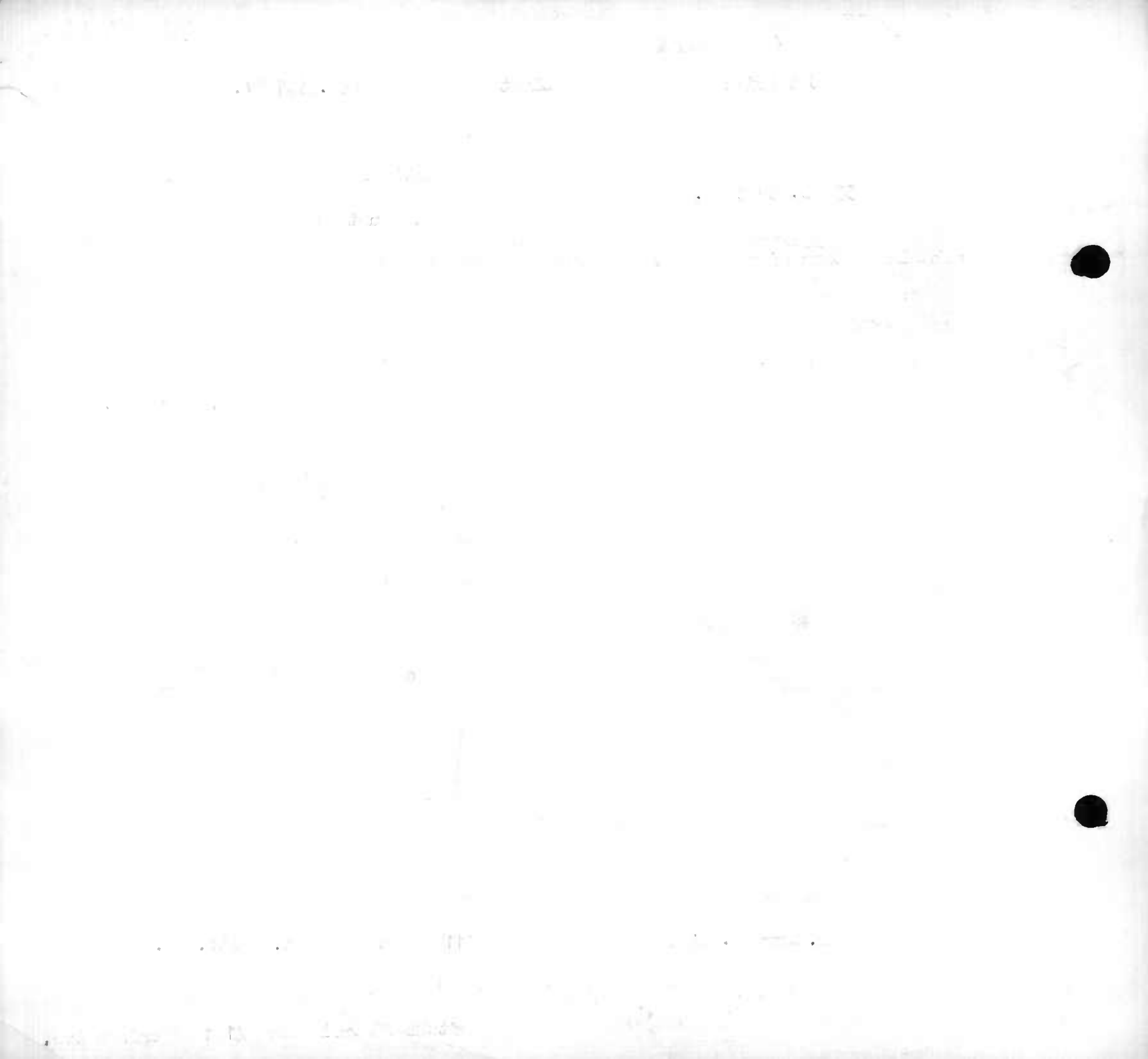
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---------|--|--|--|------------------|--|
| B-263 | | 71 0610 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0610 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) WILLIAM A BOUGOURD | | | |
| 2. DATE AND HOUR OF DEATH 1-18-71 4:00 P M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD THE JOHNS HOPKINS HOSPITAL | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) MARYLAND | | | | 5. SEX MALE | | | |
| 6. RACE WHITE | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 1-14-03 | | | | 9. AGE (In years lost birthday) 68 | | | |
| 10. A. STATE MARYLAND | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME JOHN BOUGOURD | | | |
| 14. MOTHER'S MAIDEN NAME ELIZABETH SWAGGARD | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II | | | |
| 16. SOCIAL SECURITY NO. 218 10 0325 | | | | 17. INFORMANT Mrs. Catherine B. Popp | | | |
| 18. ADDRESS 409 N. Rose St. | | | | 19. CAUSE OF DEATH Cardiac arrest | | | |
| 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bradycardia | | | | 21. ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery disease | | | |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II | | | | 23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 3/18/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED decompressive coronary artery bypass 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) --- 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) --- 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) --- 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? --- | | | |
| 24. I certify that (I) (this hospital) attended the deceased from January 17, 1971 to January 18, 1971 , that (I) (we) last saw the deceased alive on January 18, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 25. SIGNATURE James K. Smolewicz, MD 26. DATE SIGNED 1/18/71 | | | |
| 27. PHYSICIAN'S NAME (Type) JAMES K. SMOLEWICZ, MD | | | | 28. ADDRESS Johns Hopkins Hospital | | | |
| 29. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 30. DATE 1-22-71 | | | |
| 31. NAME OF CEMETERY or CREMATORY CEDAR HILL Cem. | | | | 32. LOCATION (City, town, or county) (State) BALTO., MD. | | | |
| 33. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | | 34. NAME OF REGISTRAR Robert E. Sabersky | | | |
| 35. FUNERAL DIRECTOR James K. Smolewicz | | | | 36. ADDRESS 2334 Jefferson St | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

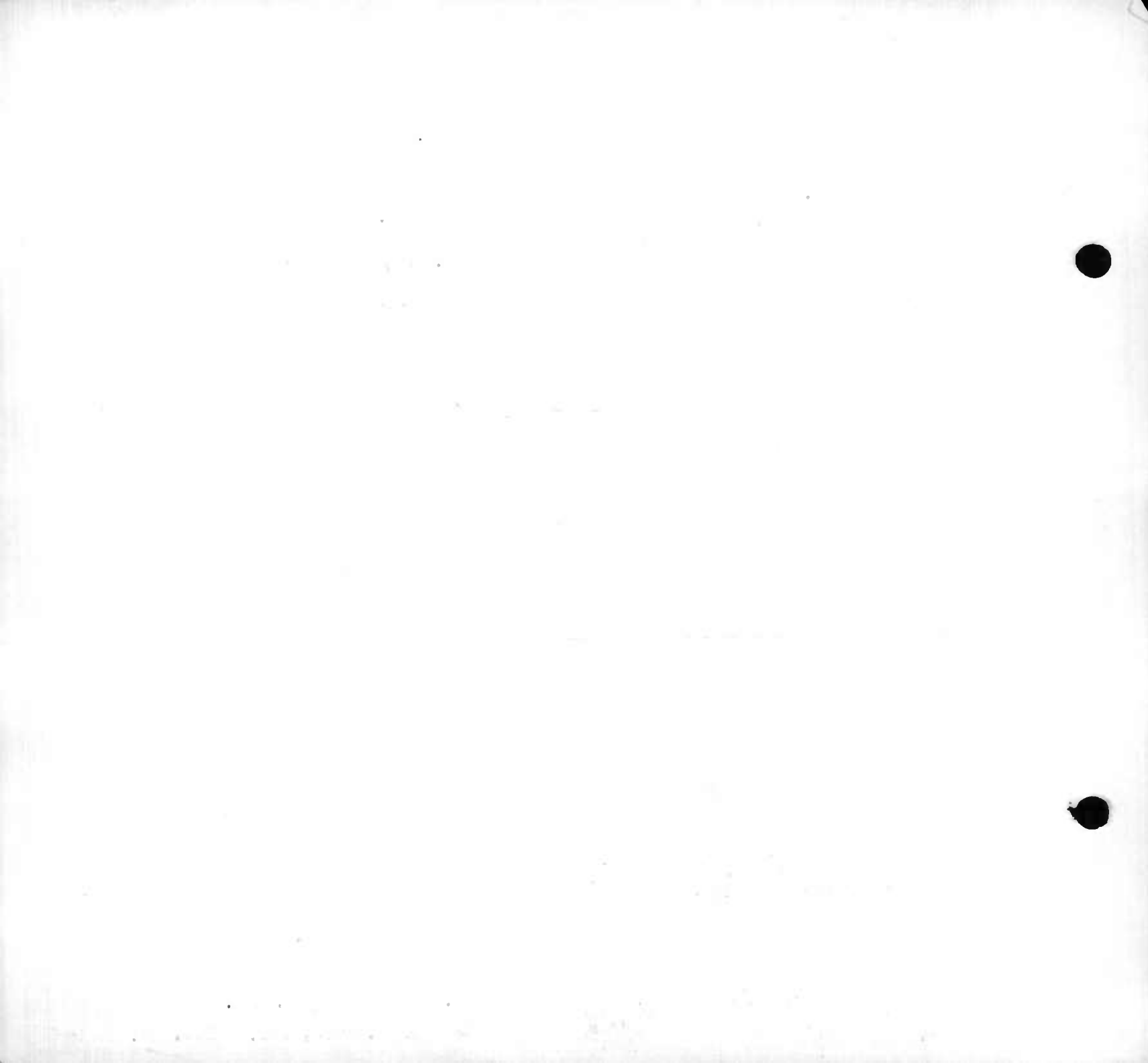
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0611 | |
|--|--|--|--|---|--|
| S-453 71 0611 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Catherine Slunt | | CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH Jan. 21, 1971. 1:00 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 00 330 S. Mount ST. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 19-03 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 330 S. Mount street | | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-6-89 9. AGE (In years last birthday) 81 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Late August Slunt | | 14. MOTHER'S MAIDEN NAME late Mary | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Miss Teresa Slunt, 330 S. Mount St. | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE acute coronary artery occlusion DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio Vasc. Disease (B) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF: (C) Parkinsonism </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-2- 1965 to 1-21 1971 that (I) (we) last saw the deceased alive on 1-20 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry L. Knipp, MD | | | | 23B. DATE SIGNED 1-21-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Harry L. Knipp | | 23D. ADDRESS 4116 Edmondson Ave. Balto. Md. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF REGISTRAR Charles E. Taylor, JR. | | 25C. FUNERAL DIRECTOR ADDRESS Witzke Funeral Home 4101 Edmondson Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

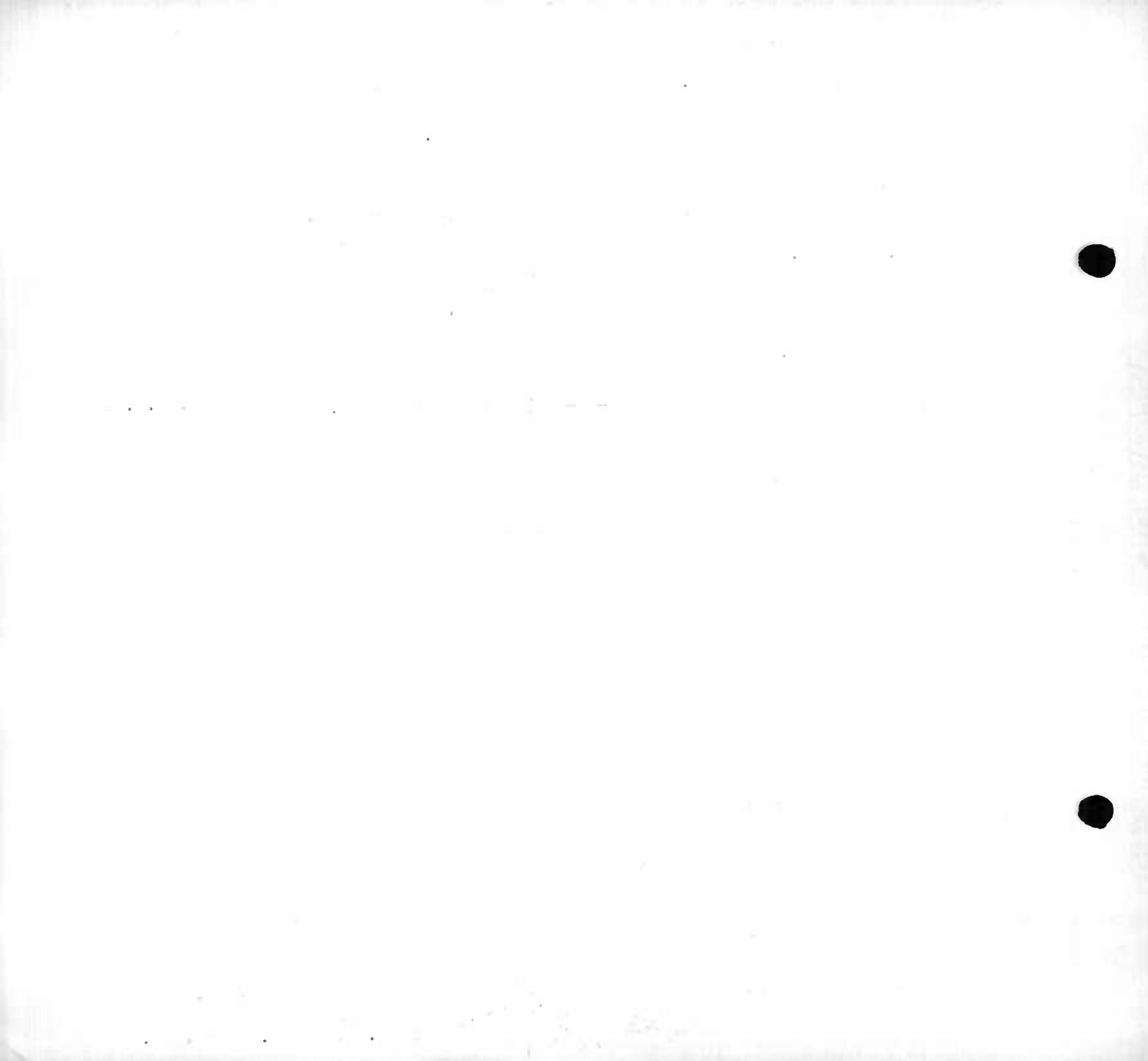
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0612 | |
|---|---|---|--|--|---|
| K-215-71 0612 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Dimos Kocovinos | | 2. DATE AND HOUR OF DEATH 1/20/71 8³⁰ P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 12-02 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 003233 St. Paul Street | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 3233 St. Paul Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 15, 1894 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Greece | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Kocovinos | | 14. MOTHER'S MAIDEN NAME Maria Pelteke | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 219-22-7205 | | 17. INFORMANT Mrs. Pauline Kocovinos ADDRESS (Same) | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 8+ yrs | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/10/62 19 to 1/20/71 19 that (I) (we) last saw the deceased alive on 12/7/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William Renner | | | | 23B. DATE SIGNED 1/20/71 | |
| 23C. PHYSICIAN'S NAME (Type) William Renner | | | | 23D. ADDRESS 3222 St. Paul Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/23/71 | | 24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------|---|--------------------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 0613 | | 71 0613 | |
| BIRTH NO. <u>B-635</u> | | 71 0613 | | CERTIFICATE OF DEATH <u>X</u> | |
| 1. NAME OF DECEASED (Type at Print) <u>AUGUSTA E. BORTNER</u> | | 2. DATE AND HOUR OF DEATH <u>1/20/71</u> <u>17:45</u> P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Edgewood Nursing Home</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6807 Bellona Ave.</u> | | | |
| 5. SEX <u>F.</u> | 6. RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/2/1889</u> | 9. AGE (in years last birthday) <u>81</u> | 10. Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>August C. Schmidt</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Wagner</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-34-5817</u> | | 17. INFORMANT <u>Miss Mildred L. Bortner</u> <u>3200 Custer Drive Wash. D.C. 20031</u> | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CORONARY HEART DISEASE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CEREBRAL VASCULAR ACCIDENTS</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (did) (did not) attend the deceased from <u>4/25</u> 19 <u>69</u> to <u>1/20</u> 19 <u>71</u> that (I) (did) last saw the deceased alive on <u>1/19</u> 19 <u>71</u> and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Donald L. Somerville</u> | | 23B. DATE SIGNED <u>1/20/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>DONALD L. SOMERVILLE</u> | |
| 23D. ADDRESS <u>25 W. PA. AVE. TOWSON, MD. 21204</u> | | 24. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>1/23/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u> | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0614 | | | |
|--|--|---|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) H. Andrew Spier Speir | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 19 71 12:35 P.M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3109 Wisteria Ave. | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 19 71 12:35 P.M. | | | |
| 6. SEX male | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27.44 | | | |
| 7. RACE white | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH Oct. 3, 1888. | | 10. AGE (In years lost birthday) 82 | | E. STREET AND NUMBER 3109 Wisteria Ave. | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Hugh Speir | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Art Industry | | | | 15. MOTHER'S MAIDEN NAME Marie Null | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 1 | | | | 17. SOCIAL SECURITY NO. 216-46-6596 | | 18. INFORMANT ADDRESS Mrs. Louise Spates, Frostburg, Md. | |
| 19. 185 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | 21. AUTOPSY? (Yes or No) no | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22F. HOW DID INJURY OCCUR? | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/19/71 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71. | | 24C. NAME OF CEMETERY or CREMATORY Frostburgh Mem. Park | | 24D. LOCATION (City, town, or county) (State) Frostburgh, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Talley, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. | | ADDRESS | |

1137 15

OFFICE OF THE SECRETARY OF THE ARMY

1130 15

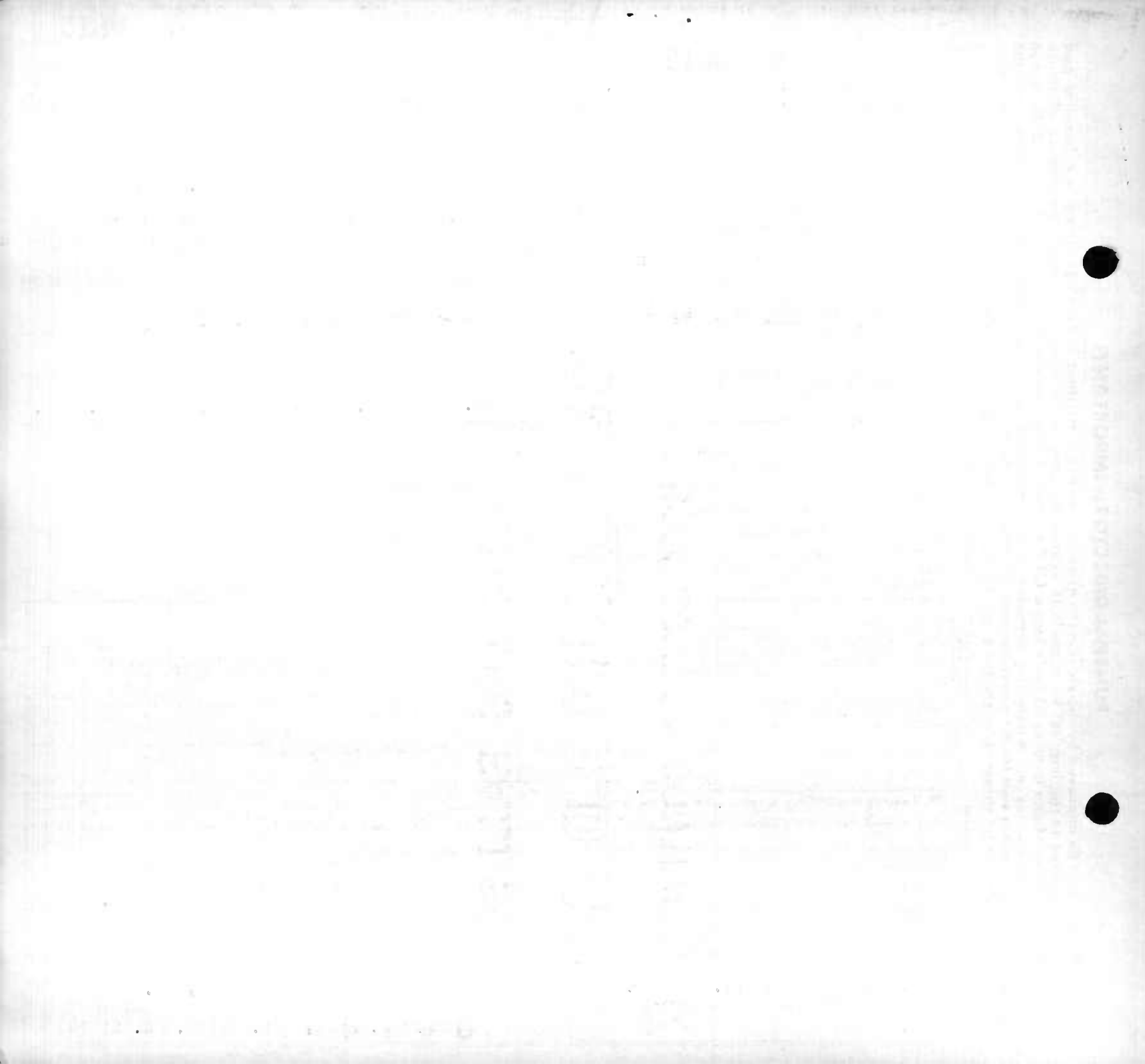
REPORT OF THE SECRETARY OF THE ARMY

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0615 | |
|--|--------------|--|-----------------------------|---|---|
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 71 0615 Holt, Oliver E. | | 2. DATE AND HOUR OF DEATH 1-20-71 1025 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 26-33 | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13 South Balto General Hosp. | | | | E. STREET AND NUMBER 3031 Chesterfield Avenue | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-17-87 | 9. AGE (In years lost birthday) 83 | 10. UNDER 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Florist | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Holt | | 14. MOTHER'S MAIDEN NAME Sarah R. Smith | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-26-8799-A | | 17. INFORMANT ADDRESS Mr. Norman A. Holt, 3030 Liberty Hgts. Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 50% of 2° + 3° burn. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) During Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) S. Light St. 23-02 | |
| 21D. TIME OF INJURY (APPROX.) 1-13-71 8:15 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? smoking in bed. | |
| 22. I certify that (this hospital) attended the deceased from 1-13-71 to 1-20-71 that (I) (we) last saw the deceased alive on 1-20-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard H. Reizo | | 23B. DATE SIGNED 1/20/71 | | 23C. PHYSICIAN'S NAME (Type) Richard H. Reizo | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/23/71 | | 24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

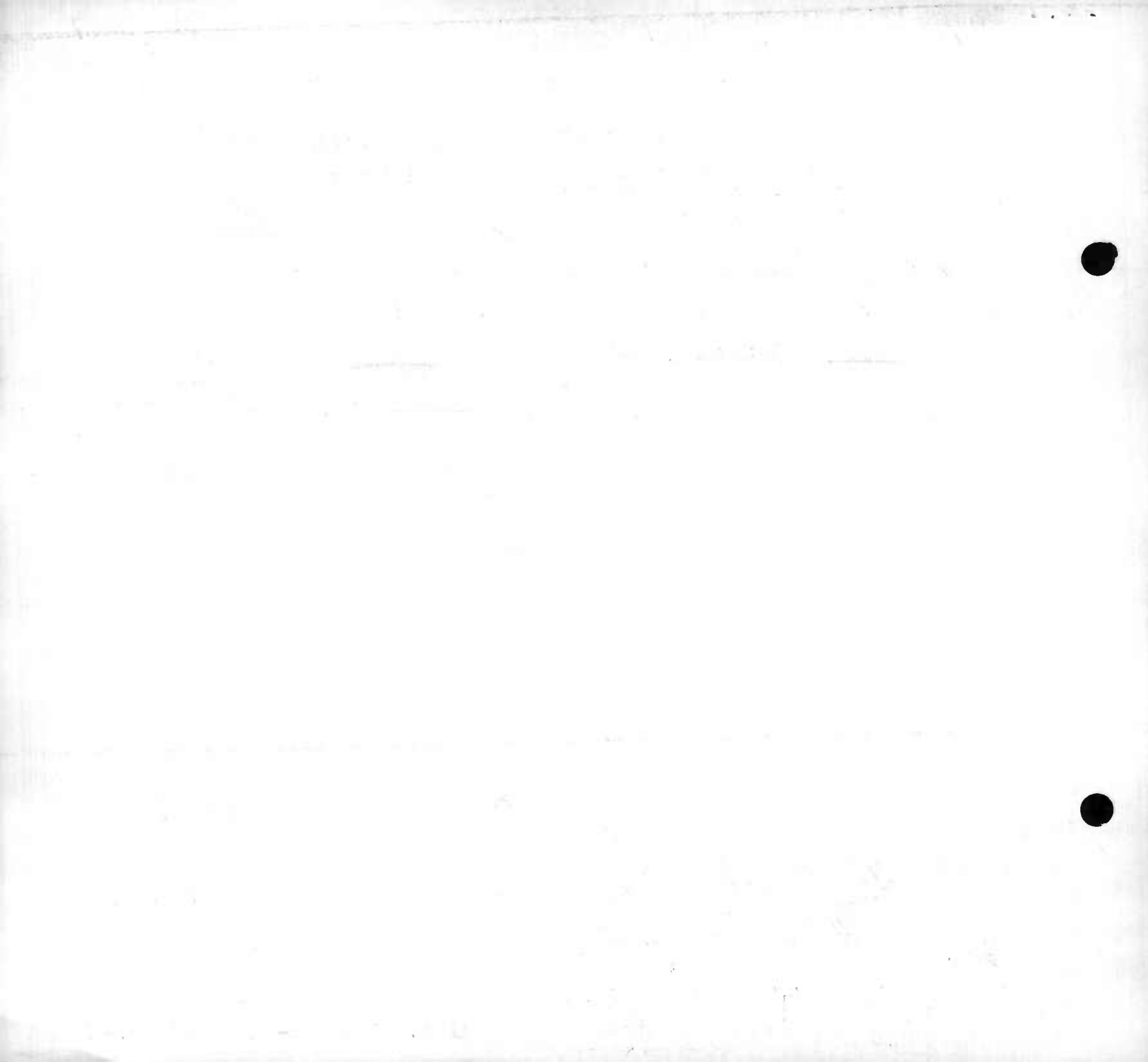
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0616</u> | |
|---|--|---|--|--|--|
| BIRTH NO. <u>71 0616</u> | | 1. NAME OF DECEASED (Type or Print) <u>MARIE V. ROACH</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>1-15-71</u> <u>12:20 P. M.</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>Baltimore Maryland</u> B. COUNTY <u>27-45</u> | | | |
| <u>Union Memorial Hospital</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-13-92</u> 9. AGE (in years last birthday) <u>78</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Ireland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>William Ward</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Coffey</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mrs. Stella White-6212 Burgess Ave.-21214</u> | |
| 18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | (C) _____ | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-06</u> 19 <u>71</u> to <u>1-15</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1-15</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>In Napiza</u> | | 23B. DATE SIGNED <u>1-15-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>MARIELY NAPIZA M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-19-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> | | 24E. FUNERAL DIRECTOR <u>John G. Miller Inc</u> | | 24F. ADDRESS <u>6415 Belair Rd.-21206</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>John G. Miller</u> | | 25C. FUNERAL DIRECTOR <u>John G. Miller Inc</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| A-200 | | 71 0617 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | 71 0617 | |
|--|---------|--|------------------|---|--|--|------------------------------|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | | | |
| | | MATILDA AUCK | | 1/17/71 | | 2:00 | | AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | | | |
| Granada Nursing Home 4017 Liberty Heights Ave. Balto., Md. 21207 | | | | Md. | | Carroll County | | 56-00 | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| | | | | Westminister | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER | | | | | |
| | | | | Rt. 5, Box 207 | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| female | white | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12/2/94 | 76 | unknown | Maryland | U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| unknown | | Christian J. Auck | | unknown | | Margaret Werner | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| no | | 218-52-2469 | | unknown | | Mrs. Margaret Bell | | 3003 Lavender | |
| 18. CAUSE OF DEATH | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CEREBRAL THROMBOSIS | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/23/70 to 1/17/71 that (I) (we) last saw the deceased alive on 1/17/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| HOLLIS DEUNALINE | | | | 1/18/71 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| HOLLIS DEUNALINE | | | | 1801 Cranbury Rd 21209 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 1-19-71 | | Baltimore Cemetery | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JAN 21 1971 | | Robert E. Talbot, Jr. | | John G. Miller Inc | | 415 Belair Rd. -21206 | | | |



S-415

71

0618

BALTIMORE CITY HEALTH DEPARTMENT

X

71

0618

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jennie Sullivan

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

42 Sinai Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

1

19

71

9:15 a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

53-00

C. CITY OR TOWN

Garrison

D. INSIDE CITY LIMITS?

YES ☐NO ☒

6. SEX

female

7. RACE

white

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

March 1, 1917

10. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

Reisterstown Rd.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alvin Eugene Shaeffer

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lillia Belle Leister

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

219-34-6992

18. INFORMANT

John H. Sullivan

ADDRESS

Reisterstown Rd.
Garrison, Md.19. E950.0

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Barbiturate overdose
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
Garrison, Md.22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

1

16

71

1:37 a.m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

ingested overdose of sleeping pills

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

1/19/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan. 22, 1971

24C. NAME OF CEMETERY OR CREMATORY

Stone Chapel Cemetery

24D. LOCATION (City, town, or county) (State)

Pikesville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1971

25B. NAME OF REGISTRAR

Robert E. Talbot, M.D.

25C. FUNERAL DIRECTOR

H. J. Schubert

ADDRESS

Owings Mills, Md.

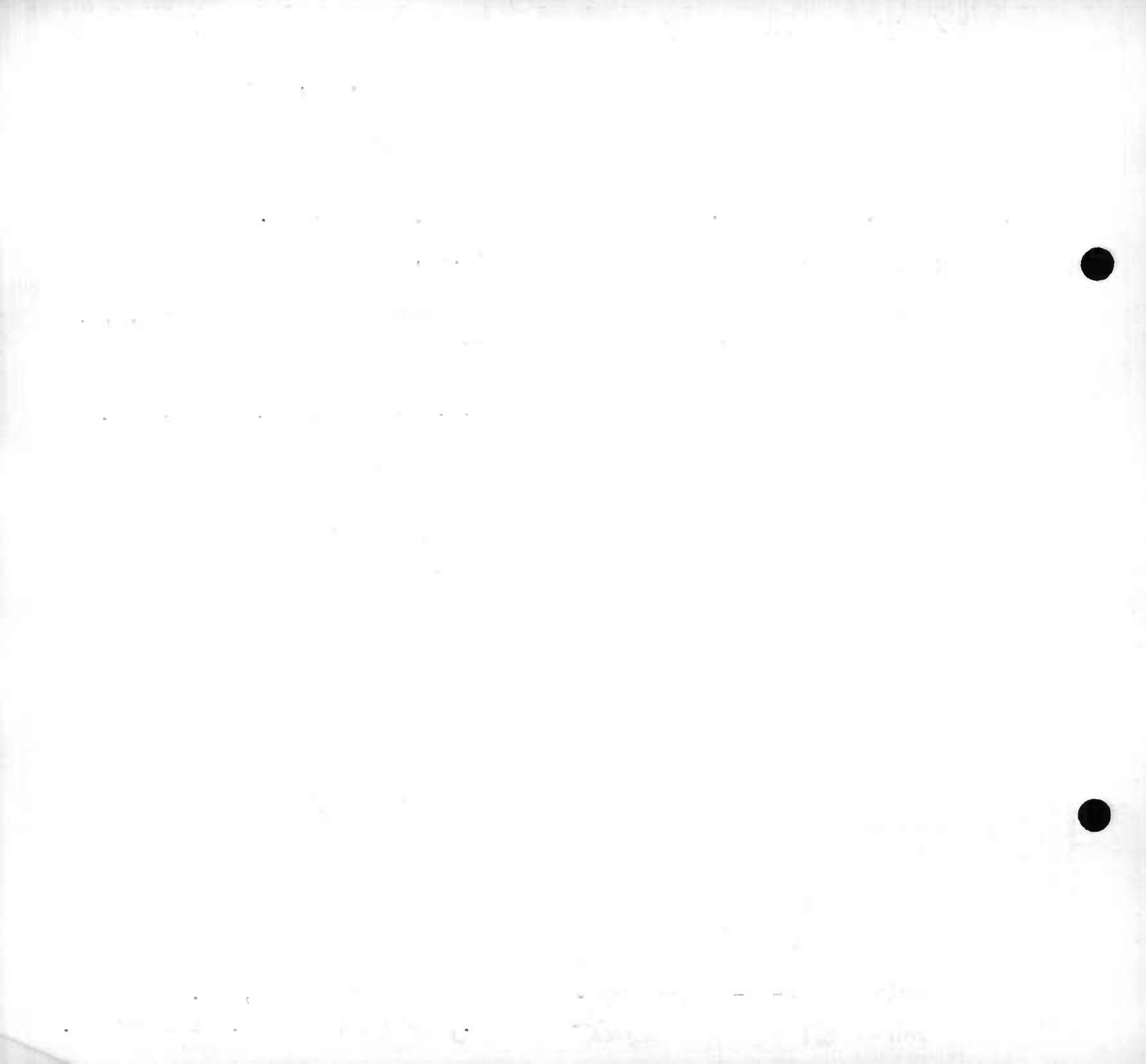
Wm. B. Smith

11/18/14

FUNERAL DIRECTOR: IMPORTANT

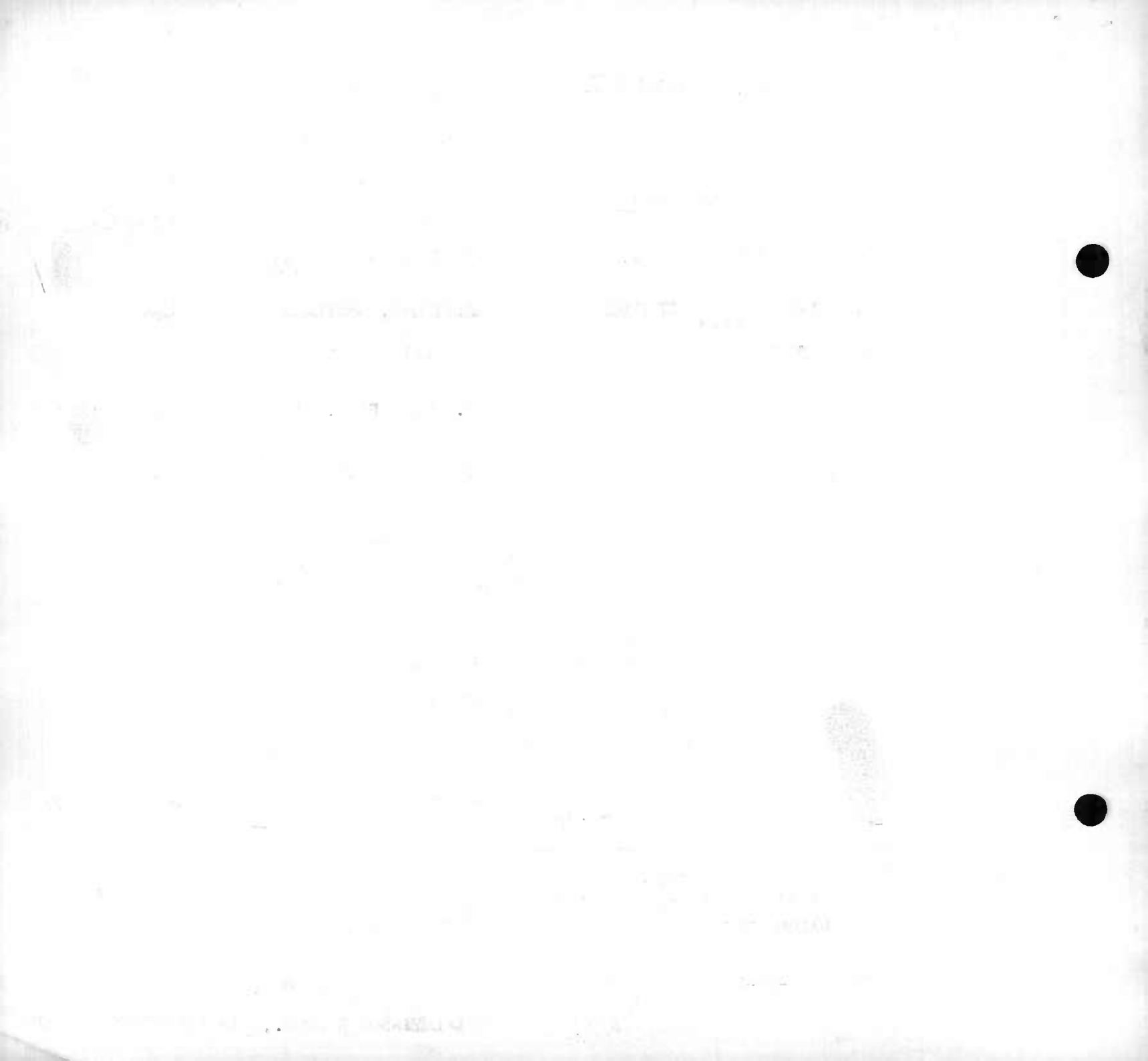
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0619 | |
|---|------------------|---|--|--|---|
| K-235 71 0619 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Catherine Kestner | | Jan. 18, 1971 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 110 N. Clinton St. | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 110 N. Clinton St. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 24, 1882 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME ----- | | |
| 14. MOTHER'S MAIDEN NAME ----- | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mr. C. Kestner 110 N. Clinton St. | | |
| 18. 410.9 I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generally art. & d. Semblity | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 19 70 to 1/18 19 71 that (I) (we) last saw the deceased alive on May 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. H. Goodman | | | | 23B. DATE SIGNED 1/19/71 | |
| 23C. PHYSICIAN'S NAME (Type) J. H. Goodman | | | | 23D. ADDRESS 9 S. High Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-21-71 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR B. Daprowski | | | |
| 25D. ADDRESS 2818 E. Baltimore St. | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

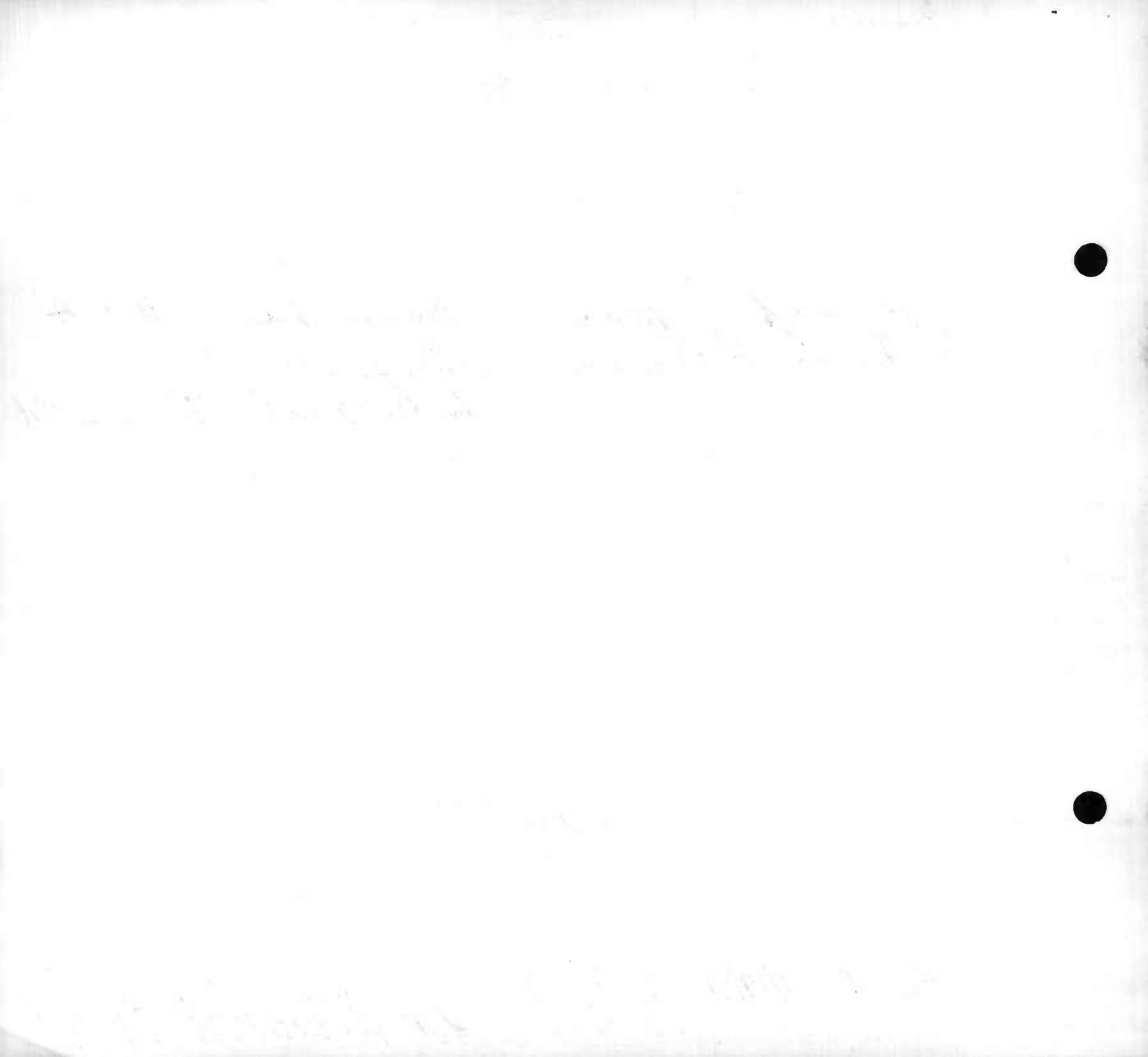
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

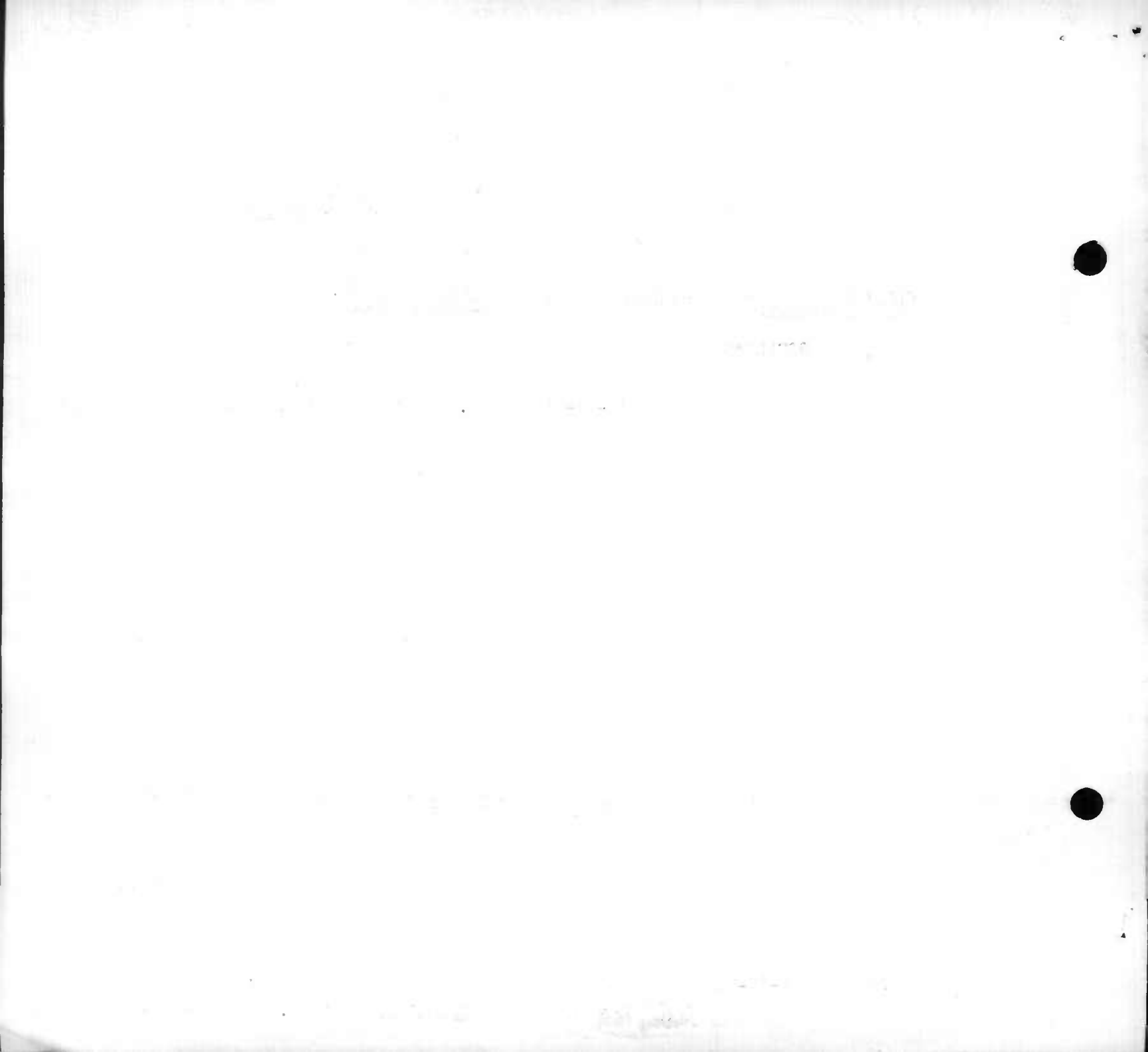
| Baltimore City Health Department | | | | CERTIFICATE OF DEATH | | REG. NO. 71 0621 | |
|--|-----------|--|--|---|-------------------------------------|--|--|
| BIRTH NO. 71 0621 | | 1. NAME OF DECEASED (Type or Print) BRILL GENEVIEVE M | | 2. DATE AND HOUR OF DEATH 1/16/71 2.30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTO. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MARYLAND. Balto Co 53-00 | | B. COUNTY | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 8610 Lucerne Rd. RANDALLSTOWN 21133 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/12/24 | 9. AGE (in years last birthday) 46. | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Mann, Va | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME E. Elmer Hellman | | | | 14. MOTHER'S MAIDEN NAME Genevieve ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lester Brill 8610 Lucerne Rd. ADDRESS | |
| 18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE CA OF BREAST DUE TO, OR AS A CONSEQUENCE OF: WITH METASTASES TO LUNGS, LIVER, BONES etc | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO- | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/15/1971 to 1/16/1971 that (I) (we) last saw the deceased alive on 1/16/71 AM 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Petras M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/16/71 | |
| 23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETRAS M.D. | | | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/17/71 | | 24C. NAME OF CEMETERY OR CREMATORY Beth El | | 24D. LOCATION (City, town, or county) (State) Randallstown Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR Sol Feinman & Bros Inc. 6010 Remondway Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

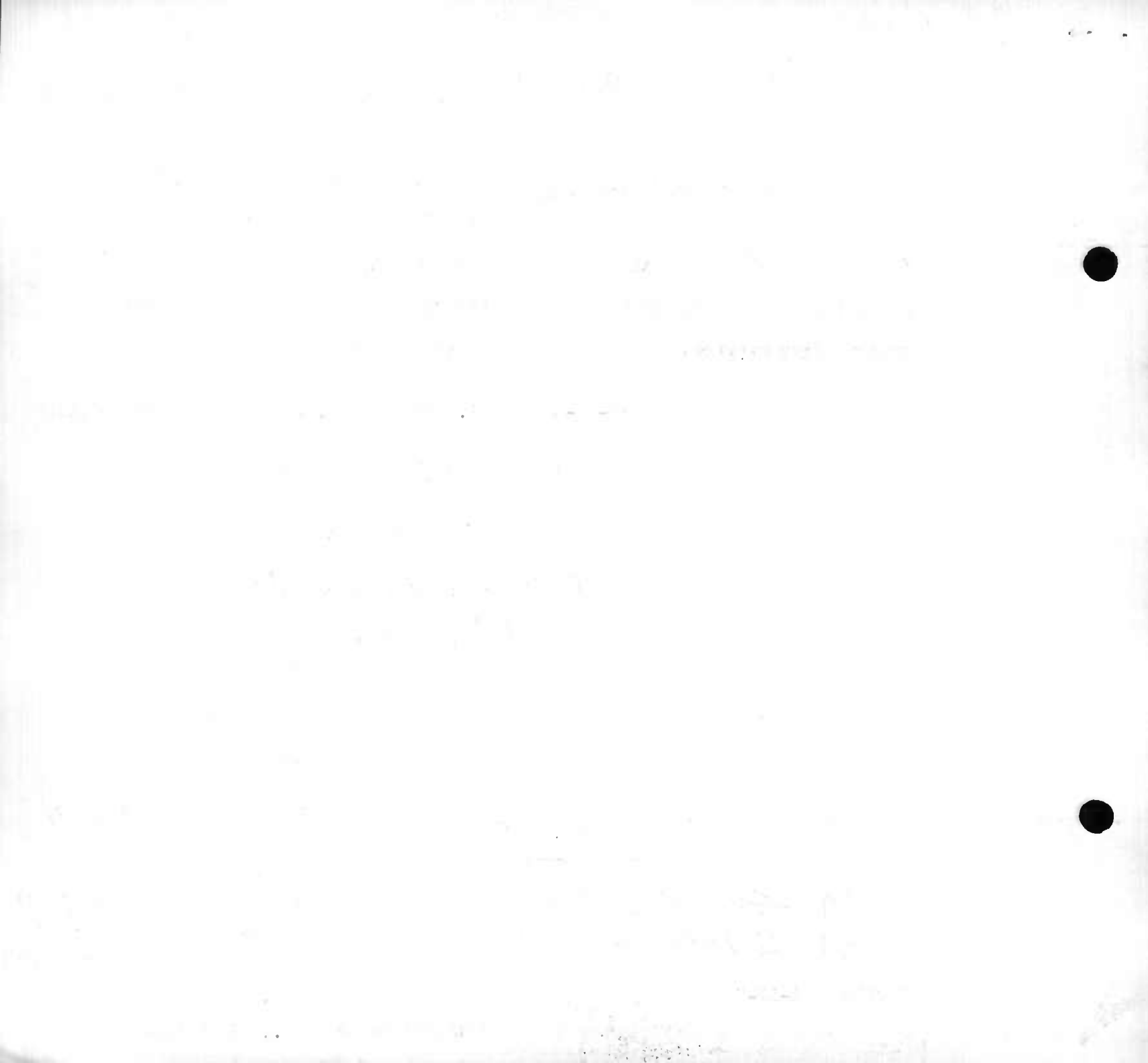
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0622 | |
|---|---------------|--|------------------------------|--|-----------------------------|
| BIRTH NO. 71 0622 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) AARON GROLLMAN | | 2. DATE AND HOUR OF DEATH 1-15-71 4:40p M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42 | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | A. STATE MARYLAND | |
| | | | | B. COUNTY | |
| | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 3904 PRIMROSE AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH XXX/XXX/XXX | 9. AGE (in years last birthday) 57 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL | | 10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL | | 11. BIRTHPLACE (State or foreign country) STEVENSVILLE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME PHILLIP GROLLMAN | | | |
| 14. MOTHER'S MAIDEN NAME LENA MARKS | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 214-01-9102 | | 17. INFORMANT ADDRESS MRS. GUSSIE GROLLMAN, 3904 PRIMROSE AVENUE | | | |
| 18. 204.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: SECONDS | | (B) Chronic Lymphocytic Leukemia YEARS | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/28/70 to 1/15/71 that (I) (we) lost saw the deceased alive on 1/15/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Franklin M.D. | | 23B. DATE SIGNED 1-15-71 | | 23C. PHYSICIAN'S NAME (Type) FRANKLIN WEINSTEIN | |
| 23D. ADDRESS SINAI HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 1-17-71 | | 24C. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH AITZ CHAIM | | 24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR SOUL LEVINSON & BROS. 6010 REISTERSTOWN ROAD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

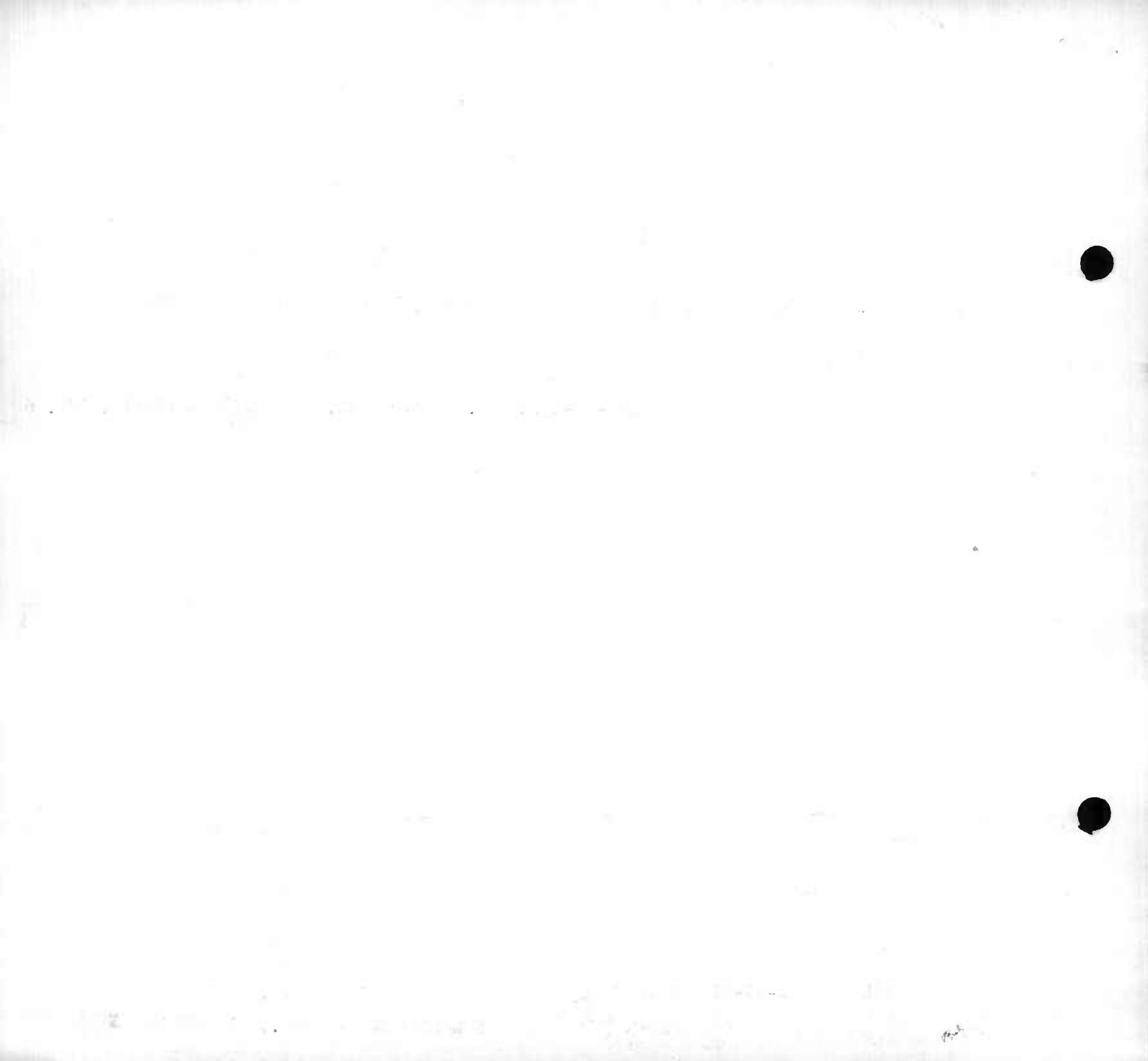
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0623 | |
|---|-------------------------|---|---|--|---|
| C-145 | | | | 71 0623 | |
| BIRTH NO. | | | | 71 0623 | |
| 1. NAME OF DECEASED (Type or Print) YETTA CAPLAN | | | 2. DATE AND HOUR OF DEATH JAN. 15, 1971 1:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE, INC 42 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2610 SUMMERSON ROAD | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 4, 1891 | 9. AGE (In years last birthday) 79 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) LITHUANIA | |
| 13. FATHER'S NAME SHOLOM HIRSH WILKINS | | | 14. MOTHER'S MAIDEN NAME MARY ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-34-8296A | | 17. INFORMANT ADDRESS MRS. HILDA FREED, 7115 BOXFORD ROAD #21215 | |
| 18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Heart Failure Arteriosclerotic Heart Disease | | | CAUSE OF DEATH Intestinal Obstruction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from JAN. 13 19 71 to JAN. 15 19 71 that (I) was last saw the deceased alive on JAN 15 19 71 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jan Sunshine M.D. | | | | 23B. DATE SIGNED Jan. 15, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) IAN SUNSHINE | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE, INC Greenspring & Belvedere Aves, Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-17-71 | | 24C. NAME OF CEMETERY OR CREMATORY ADATH YESHURUN (SODOVA) | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF REGISTRAR John E. [unclear] | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

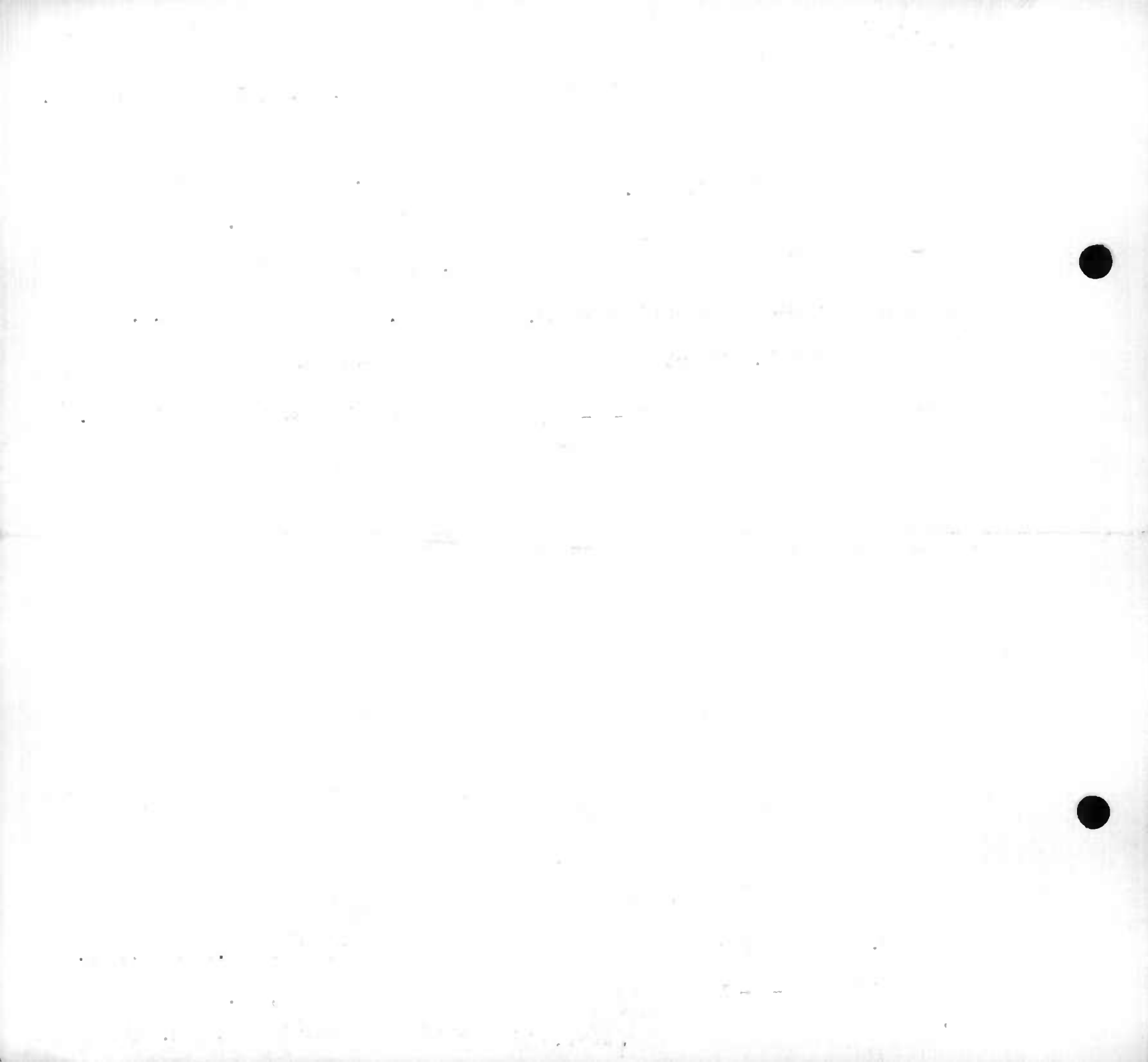
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0624 |
|---|--|---|--|---|
| BIRTH NO. K-320 | | 71 0624 | | |
| 1. NAME OF DECEASED (Type or Print) HARRY Leon KATZ | | 2. DATE AND HOUR OF DEATH 1-14-71 7:50 a.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42 | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARCHITECT-ENGINEER | | 10B. KIND OF BUSINESS OR INDUSTRY BUILDING | | 8. DATE OF BIRTH XXXXXXXXXX 9. AGE (In years last birthday) 76 |
| 11. BIRTHPLACE (State or foreign country) BOSTON, MASSACHUSETTS | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME JACOB KATZ | | 14. MOTHER'S MAIDEN NAME RACHAEL ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-03-4035 | | 17. INFORMANT MR. GERALD KATZ, 3 STONEHENGE CIRCLE, APT. 6 |
| 18. 41231 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF: | | | | SECONDS |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) ACUTE CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF: | | | | HOURS |
| (C) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | YEARS |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 1/11/71 to 1/14/71 that (I) (we) last saw the deceased alive on 1/14/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Franklin M. Weinstein MD | | 23B. DATE SIGNED 1-14-71 | | 23C. PHYSICIAN'S NAME (Type) FRANKLIN WEINSTEIN MD |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-17-71 | | 24C. NAME of CEMETERY or CREMATORY BETH TFILOH |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME of REGISTRAR John E. Fisher, Jr. | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERS TOWN |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

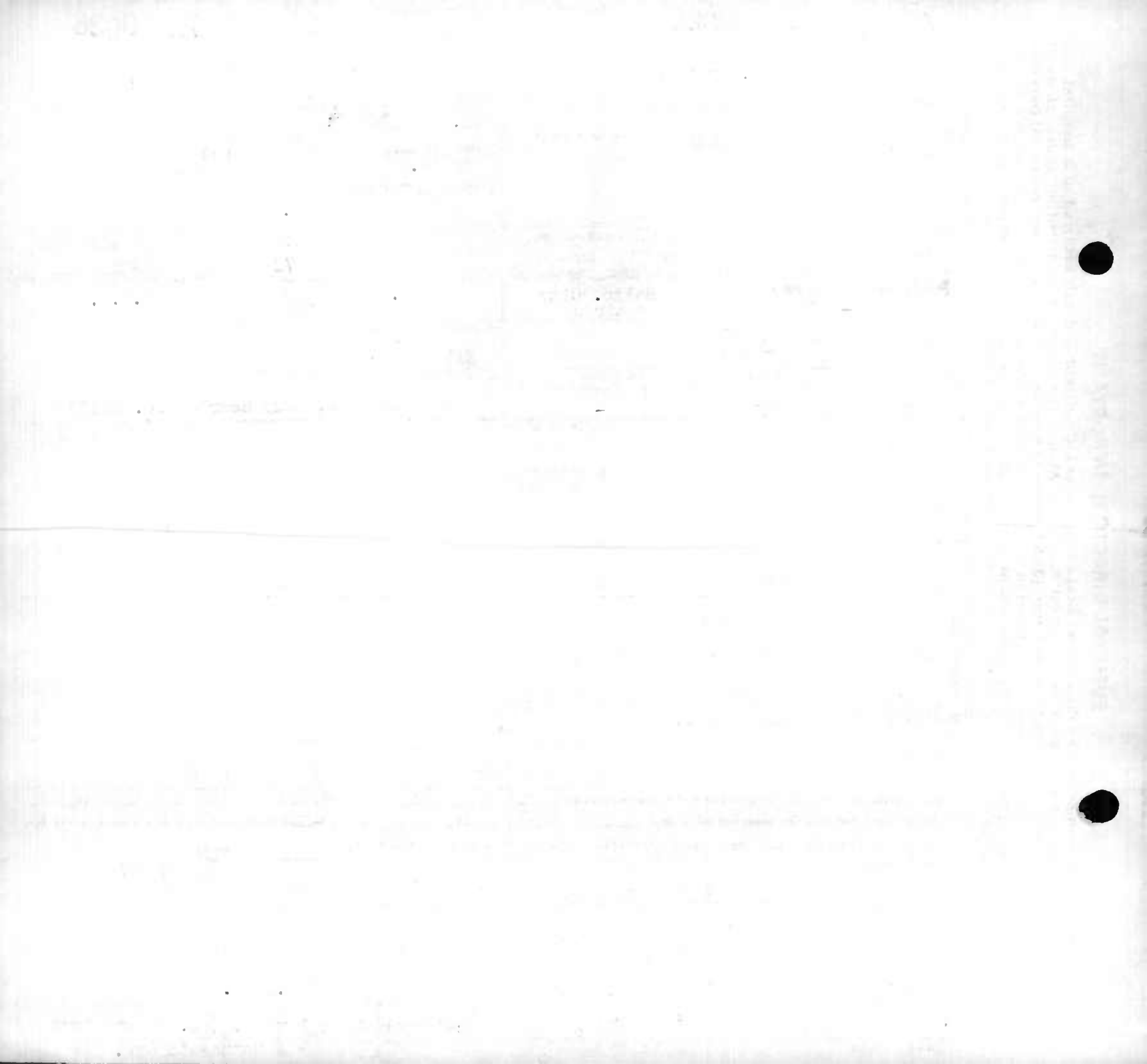
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0625</u> |
|---|--------------|---|----------------------------------|---|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| William Percy Lippert | | Jan. 18, 1971 8:10 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3324 Lawnview Ave. | | A. STATE Maryland | | |
| | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER 3324 Lawnview Ave. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 8, 1905 | 9. AGE (in years last birthday) 66 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sampler & weigher | | 10B. KIND OF BUSINESS OR INDUSTRY American Sugar Co. | | 11. BIRTHPLACE (State or foreign country) Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Charles E. Lippert | | |
| 14. MOTHER'S MAIDEN NAME Mary Mertz | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | |
| 16. SOCIAL SECURITY NO. 212-09-5857 | | 17. INFORMANT Evelyn Lippert, 3324 Lawnview Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ca of Rectum</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> 19 <u>70</u> to <u>1/18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <i>Dr. Julius Goodman</i> | | 23B. DATE SIGNED 1/18/71 | | 23C. PHYSICIAN'S NAME (Type) Dr. Julius Goodman |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 1-21-71 | | 24C. NAME of CEMETERY or CREMATORY Parkwood |
| 24D. LOCATION Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | |
| 25B. NAME OF REGISTRAR <i>E. E. E. E. E.</i> | | 25C. FUNERAL DIRECTOR Schmunk Funeral Home, Inc. Brehms Lane | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

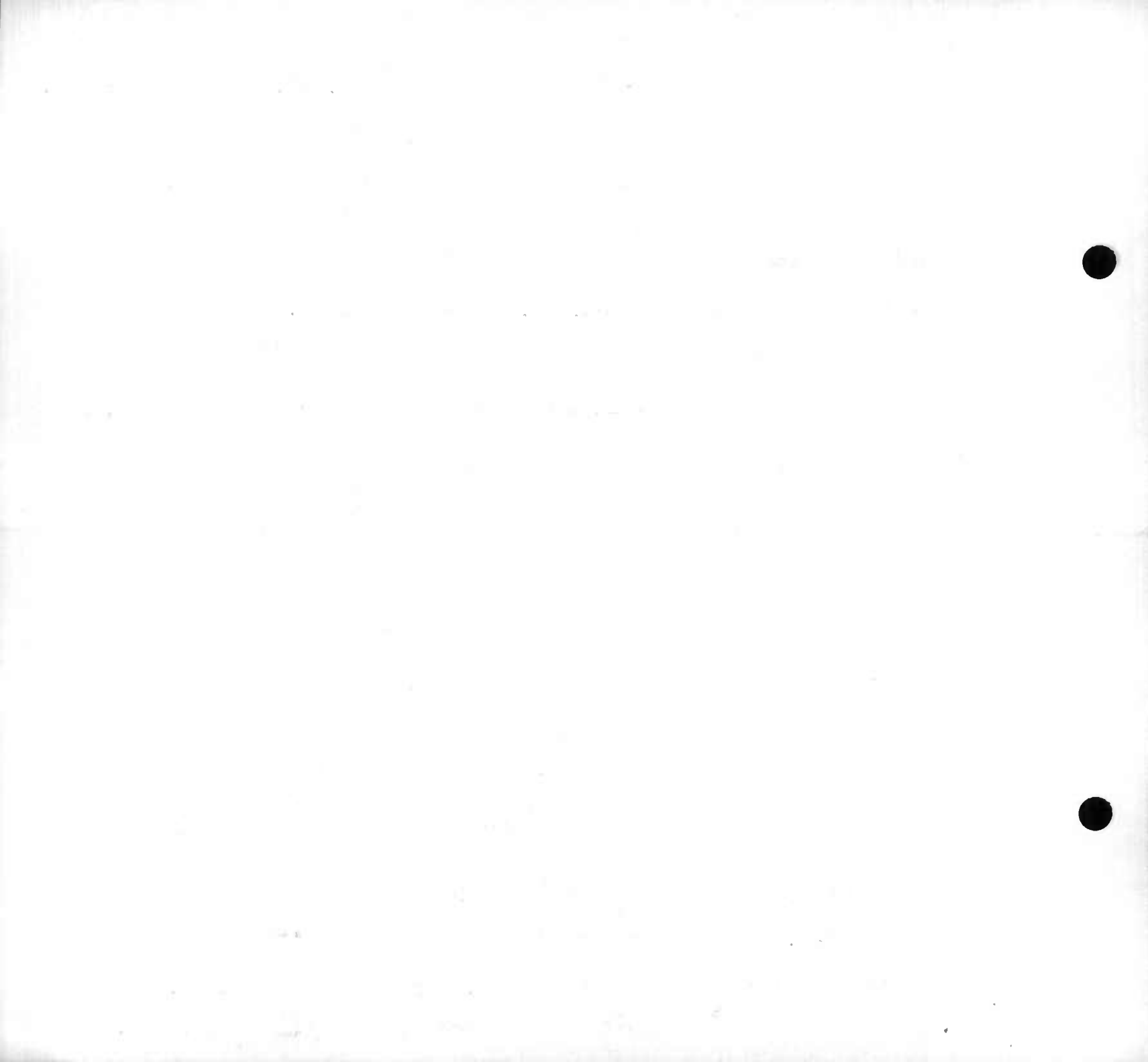
| BIRTH NO. <u>T-656</u> <u>71</u> <u>0626</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH <u>X</u> | | REG. NO. <u>71</u> <u>0626</u> | |
|---|------------------|---|------------------------------------|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>Charles P. Trainor</u> | | | | 2. DATE AND HOUR OF DEATH <u>1/18/71</u> <u>9:40</u> <u>P</u> <u>M.</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> <u>37</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1629 Searles Rd.</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/13/99</u> | 9. AGE (In years lost birthday) <u>72</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman-retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Patrick Trainer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ellen Lynch</u> | | | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Navy</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Grace Trainor, 1629 Searles Rd. 21222</u> | | | | | |
| 18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CONGESTIVE HEART FAILURE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>0</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/6/71</u> to <u>1/18/71</u> and that (I) (we) lost saw the deceased alive on <u>1/18/71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | 23B. DATE SIGNED <u>1/19/71</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Ky1 K Lwin</u> | | | | 23D. ADDRESS <u>Mercy Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>1/22/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR <u>[Signature]</u> | | ADDRESS <u>Schwimnek Funeral Home, Inc. Brehms Lane</u> <u>& Mannasota Ave.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

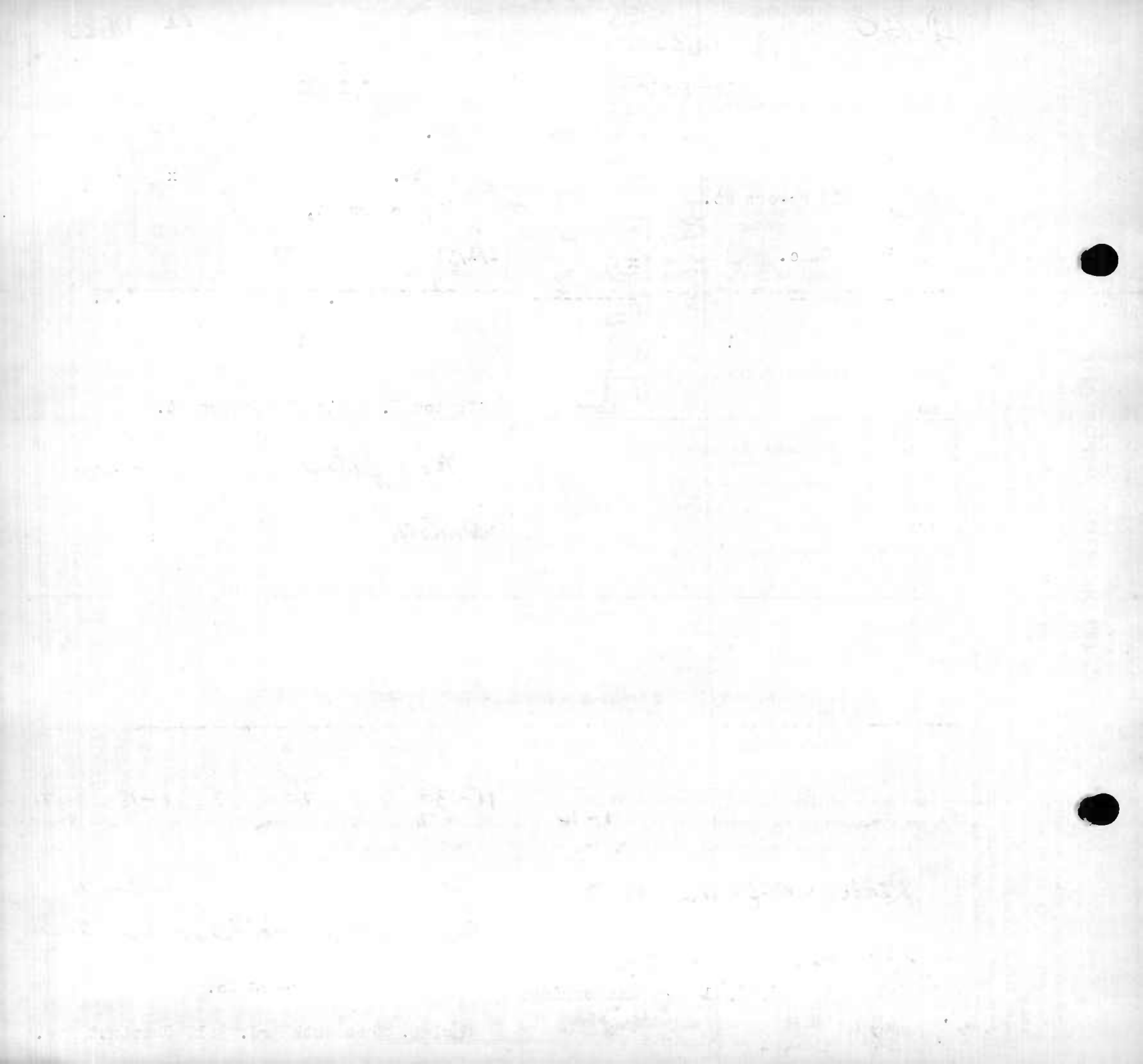
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0627 | |
|--|--|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> 1-520 71 0627 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | CHARLES H. YOUNG | | Jan. 18, 1971 12:22 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital | | | A. STATE Md., 21213 | | |
| | | | B. COUNTY | | |
| 5. SEX male | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 3122 Clifftmont Avenue | | |
| 6. RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/16/02 | |
| 9. AGE (in years last birthday) 68 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 10B. KIND OF BUSINESS OR INDUSTRY Davidson Chem. Co. | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME John Young | | | 14. MOTHER'S MAIDEN NAME Margaret Vogelsang | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 14-03-2534T | | 17. INFORMANT Henrietta Storey Young, wife, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE CARDIO-VASCULAR DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 15 years | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II _____ | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 27 1969 to January 18 1971 that (I) (we) last saw the deceased alive on January 7 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Grafton Hersperger M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Dr. W. Grafton Hersperger | | | | 23D. ADDRESS Medical Arts Building | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/20/71 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0628 | |
|--|---|---|---|--|---|
| BIRTH NO. 1-20 | | 71 0628 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Helen Davis | | | 2. DATE AND HOUR OF DEATH 1/18/71 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Md. | | |
| 00 819 Powers St. | | | C. CITY OR TOWN Balto. | | |
| | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 819 Powers St. | | |
| 5. SEX Female | 6. RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/1/91 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME ? | | | 14. MOTHER'S MAIDEN NAME ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | none | | Clayton E. Davis 819 Powers St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Heart failure | | |
| ANTECEDENT CAUSES | | | (B) senility | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 1-20-71 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-30 19 70 to 1-18 19 71 , that (I) two last saw the deceased alive on 1-16 19 71 and that in (my) your opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rueben Hoffman, M.D. | | | | 23B. DATE SIGNED 1-20-71 | |
| 23C. PHYSICIAN'S NAME (Type) Rueben Hoffman | | | | 23D. ADDRESS 846 W. 36th St., Baltimore, Md. 21211 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1/21/71 | | Meadowridge | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS Paul E. Chenoweth 3rd, 3617 Chestnut Ave. | |



F-630 71 0629
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 0629

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Albert Eugene Ford | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 17 71 3:10 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 139 Willard Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 71 3:10 p.m. | |
| 6. SEX male | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8-31-1908 | | 10. AGE (In years lost birthday) 62 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Royal A. Ford | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 20-04 | |
| 15. MOTHER'S MAIDEN NAME Helen Rush | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 212-05-8631 | | 18. INFORMANT Allen E. Ford | |
| 19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/18/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-21-1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Meadowridge | | 24D. LOCATION (City, town, or county) (State) Dorsey, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Seib | |
| 25C. FUNERAL DIRECTOR Truman Schwab | | ADDRESS 3512 Frederick Ave | |

8320

15

THE UNIVERSITY OF CHICAGO

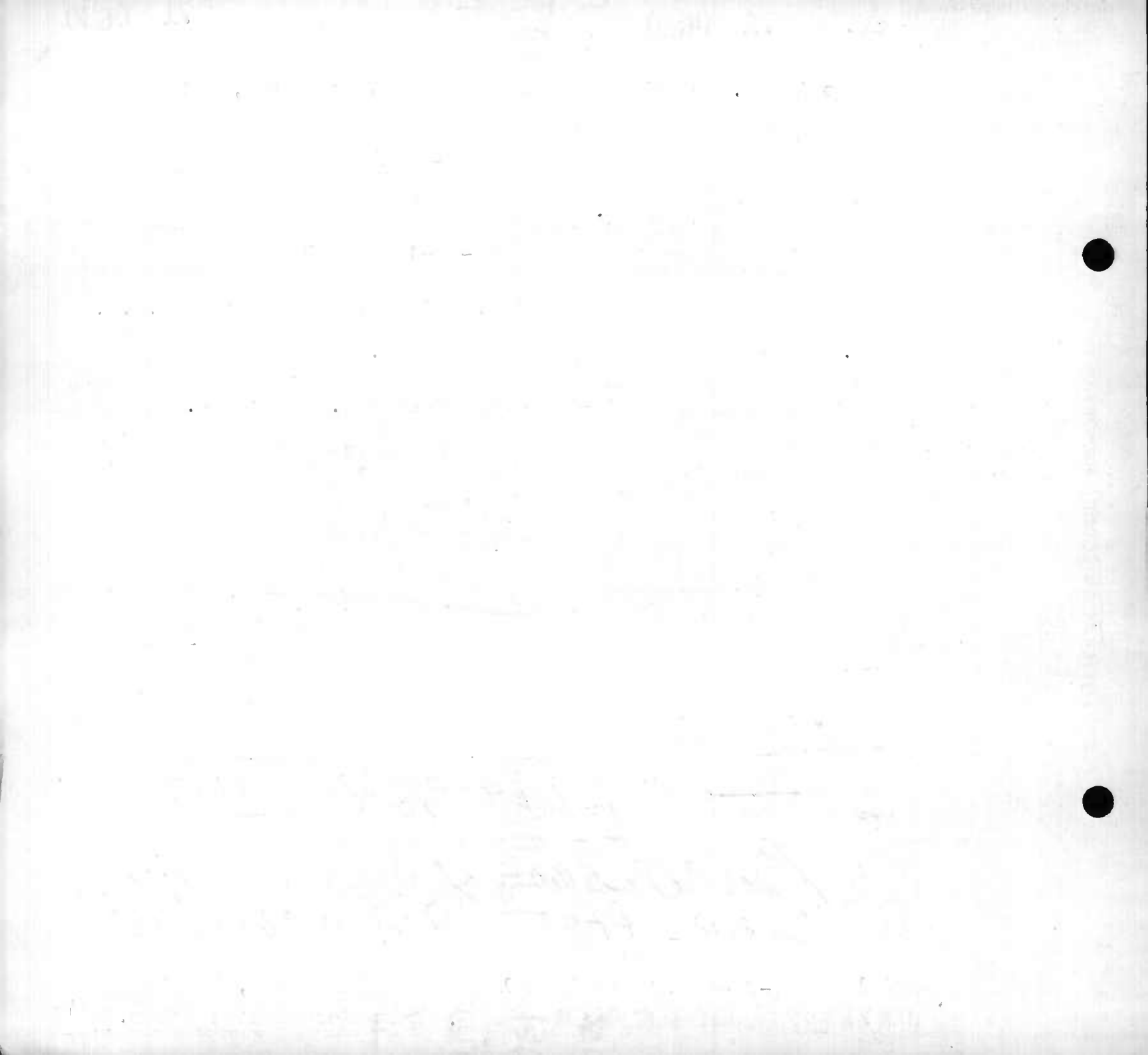
1954

ACADEMIC RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

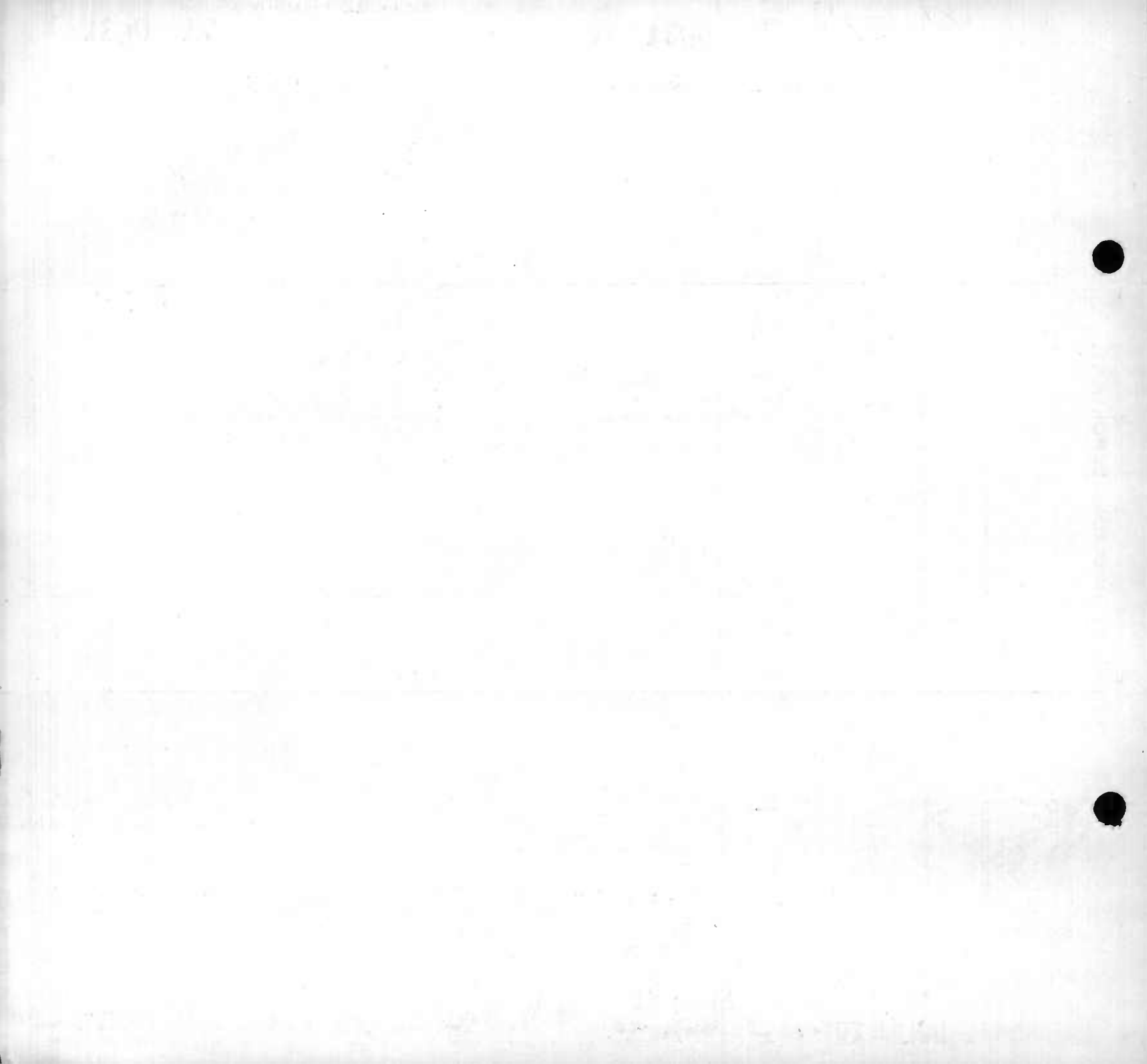
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0630 | |
|---|--|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> S-100 71 0630 </div> | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| <div style="text-align: center;"> Rosina E. Schaub </div> | | | <div style="text-align: center;"> January 17, 1971 </div> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.5em;">00</div> </div> <div style="flex: 1;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4426 Forest View Road </div> </div> | | | <div style="display: flex;"> <div style="flex: 1;"> A. STATE Maryland </div> <div style="flex: 1;"> B. COUNTY Baltimore </div> </div> | | |
| 5. SEX | | | 6. DATE OF BIRTH | | 9. AGE (In years last birthday) |
| <div style="display: flex;"> <div style="flex: 1;">Female</div> <div style="flex: 1;">White</div> </div> | | | <div style="display: flex;"> <div style="flex: 1;"> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> </div> <div style="flex: 1;"> 5-19-1895 </div> </div> | | 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | Baltimore, Maryland | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| John H. Sellman | | | Mary E. Boss | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| | | | 212-24-9938A | | |
| 17. INFORMANT | | | ADDRESS | | |
| | | | 4426 Forest View Road | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| 412.4 I | | | CVA | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| <div style="text-align: center;"> ANTECEDENT CAUSES </div> | | | ASCVD | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| <div style="text-align: center;"> II </div> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | <div style="display: flex;"> <div style="flex: 1;">White At Work <input type="checkbox"/></div> <div style="flex: 1;">Not White At Work <input type="checkbox"/></div> </div> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-30-67 19 to 1/17 19 71 , that (I) (we) last saw the deceased alive on 12/14 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Pearl Pass | | | | 1/19/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| PEARL PASS | | | | 4001 Wilkens Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1-20-1971 | | New Cathedral | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 21 1971 | | Robert E. Schaub | | G. Truman Schwab | |
| | | | | ADDRESS | |
| | | | | 5151 Balto. Nat'l Pike | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

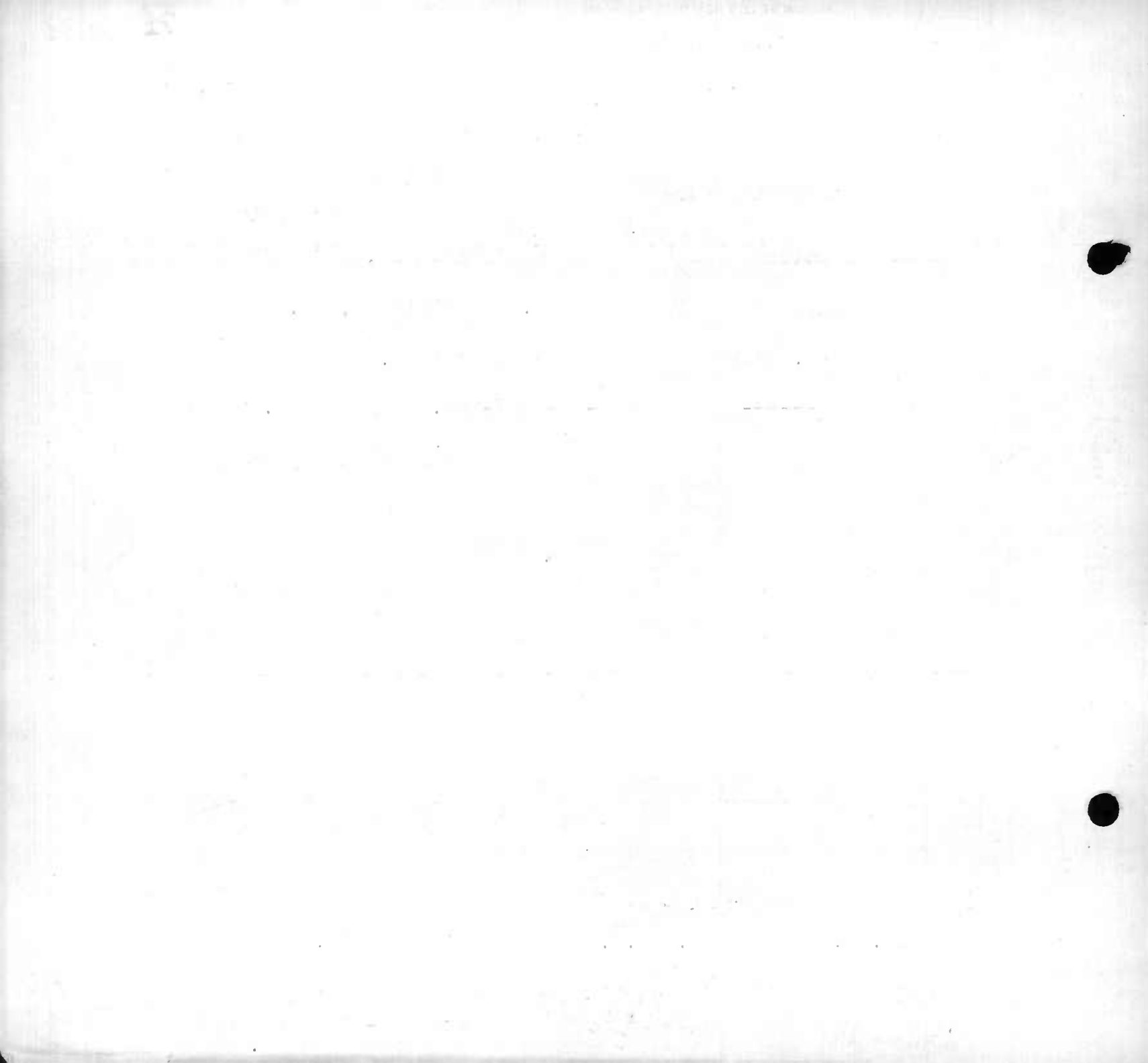
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0631 |
|--|----------------------------|---|--|---|
| BIRTH NO. G-431 | | 71 0631 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED (Type or Print) <i>Sophia Goldberg</i> | | 2. DATE AND HOUR OF DEATH <i>1/19/71 2:45 p. M.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>6968 Marvue Drive</i> <i>00</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>28-31</i> C. CITY OR TOWN <i>Balto</i> E. STREET AND NUMBER <i>4113 Newbarn Ave</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <i>2/8/1896</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Semstress</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) <i>74</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>max</i> | | 14. MOTHER'S MAIDEN NAME <i>Martha</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>217-16-1968</i> | | 17. INFORMANT <i>Charles Goldberg</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH <i>Acute Myocardial infarction</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 MINS</i> |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Aug 15 1969</i> to <i>JAN 19 1971</i> , that (I) (we) last saw the deceased alive on <i>Dec 18 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <i>Albert J. Himelfarb</i> | | | | 23B. DATE SIGNED <i>1/20/71</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>ALBERT J. HIMELFARB</i> | | 23D. ADDRESS <i>222 W. Goldsprung Lane Balto 21210</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/21/71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Beth Teflok</i> |
| 24D. LOCATION (City, town, or county) (State) <i>Balto md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1971</i> | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Faber, Md.</i> | | 25C. FUNERAL DIRECTOR <i>Sharon Levine & Son 9610 Reisterstown Rd</i> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

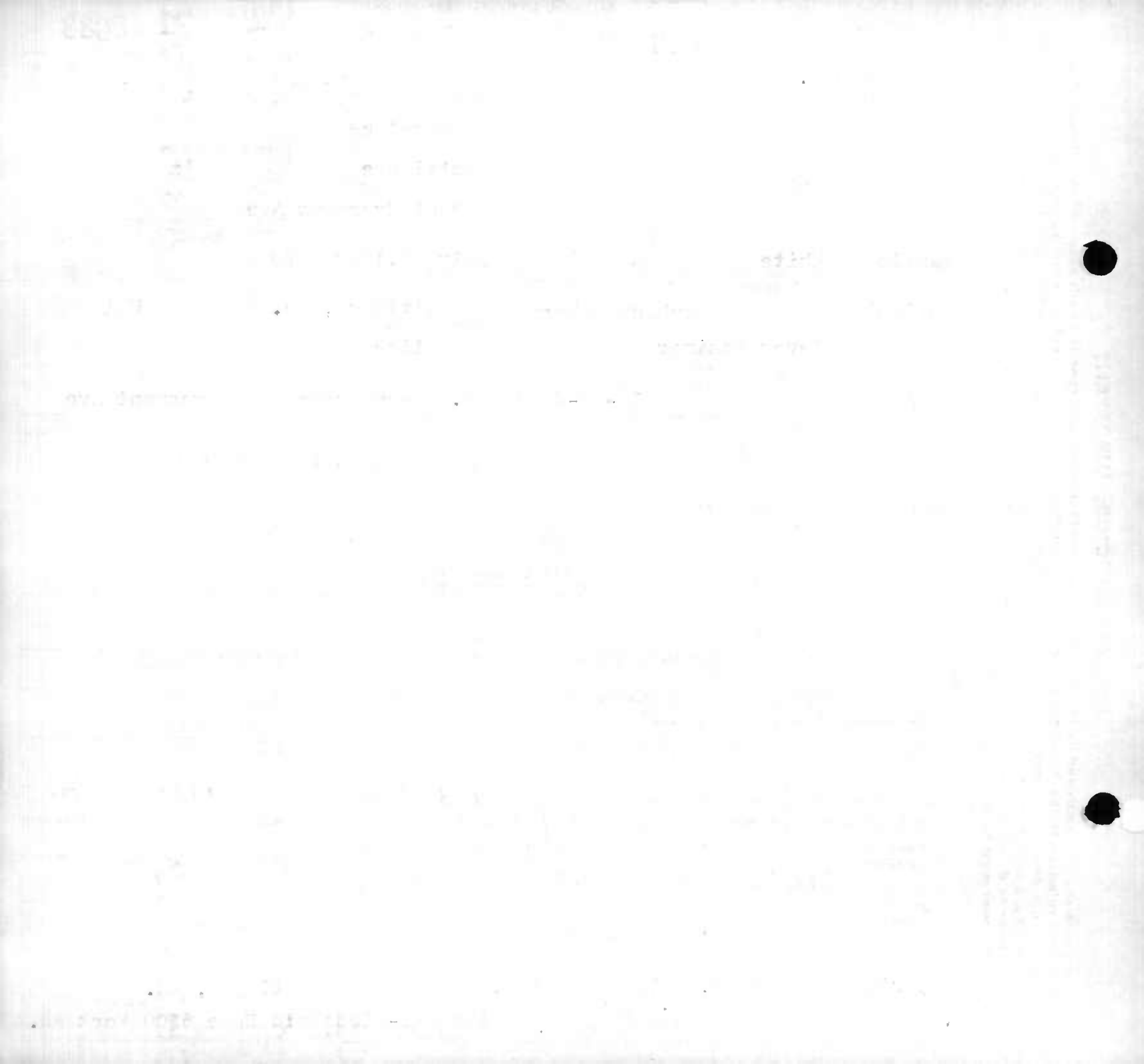
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 71 0632 |
|---|--------------------------------|---|--|--|--|
| B-420 71 0632 CERTIFICATE OF DEATH | | BIRTH NO. 1. NAME OF DECEASED (Type or Print) JOSEPH F. BLAKE | | 2. DATE AND HOUR OF DEATH January 17th, 1971 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Edgewood Nursing Home | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-39 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4616 Northwood Drive | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 21, 1898 | 9. AGE (In years last birthday) 72 If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate | | 10B. KIND OF BUSINESS OR INDUSTRY City of Balto. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James A. Blake 14. MOTHER'S MAIDEN NAME Annie E. Mullan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213-34-5547 | | 17. INFORMANT Mrs. Catherine B. Blake ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ca Right Lung 4 mo APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 19 61 to Jan 19 71, that (I) (we) last saw the deceased alive on Jan 12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm. H. Kammer, Jr. DEGREE | | | | 23B. DATE SIGNED Jan. 19, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Wm. H. Kammer Jr. M.D. DEGREE | | | | 23D. ADDRESS 6011 York Rd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/20/71 | | 24C. NAME of CEMETERY or CREMATORY Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. STATE MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Sabers | | 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

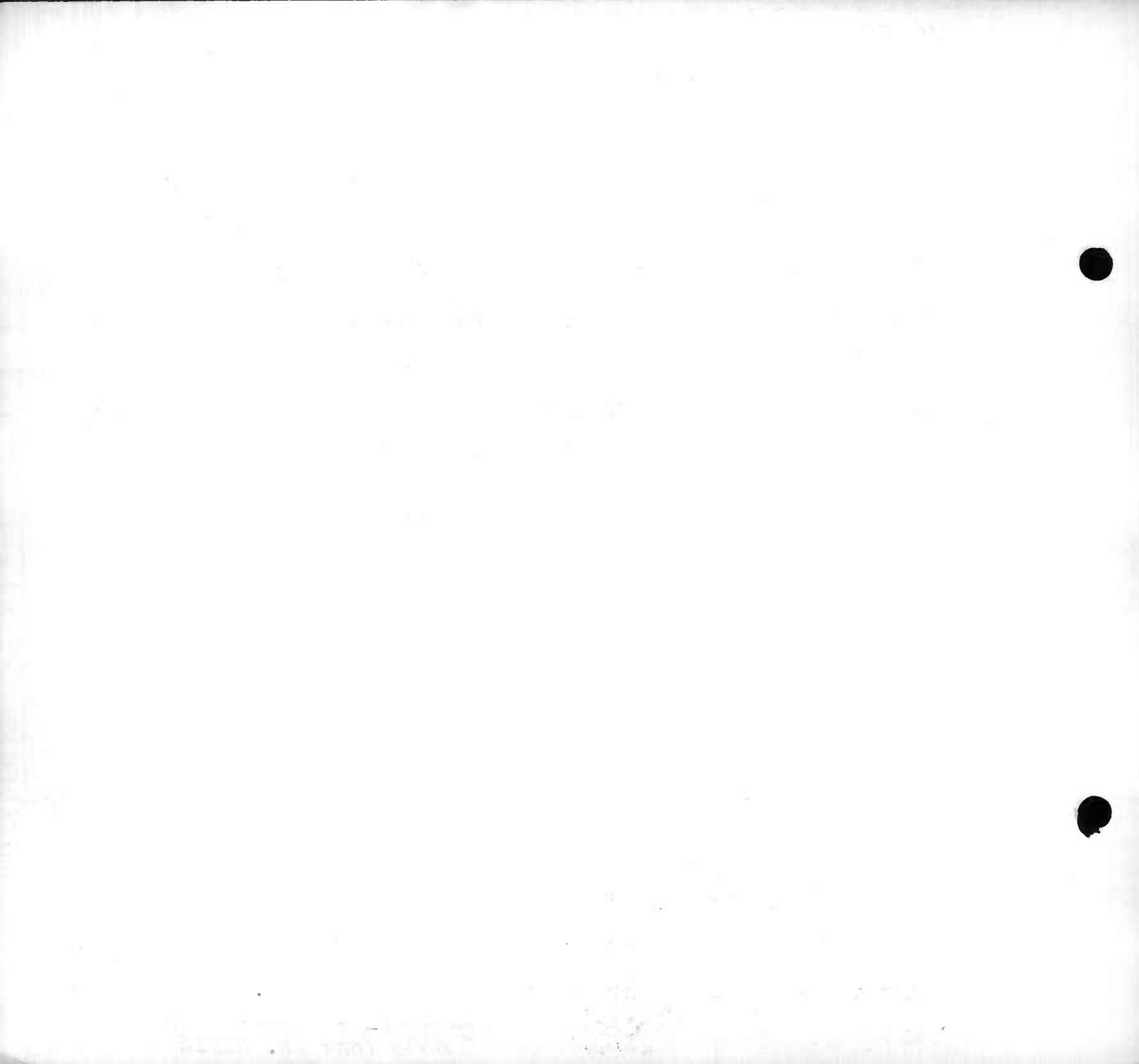
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0633</u> | |
|---|-------------------------|---|--|---|---|
| S-160 BIRTH NO. | | 71 0633 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Lydia F. Sparrow</u> | | | 2. DATE AND HOUR OF DEATH <u>1-12-71</u> <u>1:55</u> A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u> <u>37</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-06</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3001 Cresmont Ave</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 22, 1900</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Muhley Bakery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>Clever Masimer</u> | | | 14. MOTHER'S MAIDEN NAME <u>Alice ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>214-20-4395</u> | | 17. INFORMANT <u>Mrs. Peggy Ayres</u> | |
| | | | | ADDRESS <u>3001 Cresmont Ave</u> | |
| 18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>Malignant cachexia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Carcinoma of Cervix</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>wide spread metastasis</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/30/70</u> to <u>1/12</u> 1971 that (I) (we) last saw the deceased alive on <u>1/12</u> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Pratima Bose MD</u> | | | 23B. DATE SIGNED <u>1/12/71</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) <u>PRATIMA BOSE MD</u> | | | 23D. ADDRESS <u>Mercy Hospital</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Jan 15, 1971</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Balto, Nat Cem</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Sabin, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u> | |
| | | | | ADDRESS <u>Home 6500 York Rd.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0634</u> | |
|---|---------------------|---|-------------------------------------|---|---|
| <div style="display: flex; justify-content: space-between;"> M-520 71 0634 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. <u>171</u> | | 1. NAME OF DECEASED <u>BRIDGET MARIE MEANS</u> (Type or Print) <u>BRIDGETT MARIE MEANS</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>44 Union Memorial Hosp.</u> | | 2. DATE AND HOUR OF DEATH <u>1-16-71</u> <u>9:00 P.M.</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp.</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>12-03</u> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>2716 GUILFORD AVE</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>06-27-00</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u> | |
| 13. FATHER'S NAME <u>JOHN QUINN</u> | | 14. MOTHER'S MAIDEN NAME <u>SARAH KENNEDY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Marion Stalnaker - SAME</u> | |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u> <u>Congestive Heart Failure</u> <u>ASCVD</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1/5/71</u> 19 <u>71</u> to <u>1/16</u> 19 <u>71</u> that (I) (<u>we</u>) last saw the deceased alive on <u>1/16</u> 19 <u>71</u> and that (in my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE <u>H. EARL COTMAN, M.D.</u> | | 23B. DATE SIGNED <u>1/16/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>H. EARL COTMAN, M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1/20/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL CEMETERY</u> | |
| 24D. LOCATION <u>BALTO.</u> | | 24E. NAME OF REGISTRAR <u>REBECCA J. BROWN</u> | | 24F. FUNERAL DIRECTOR <u>MOTCHELL-WIEDEFELD HOME</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>REBECCA J. BROWN</u> | | 25C. FUNERAL DIRECTOR <u>MOTCHELL-WIEDEFELD HOME</u> | |
| | | | | ADDRESS <u>6500 YORK RD. 21212</u> | |



F-616

71 0635

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0635

BIRTH NO.

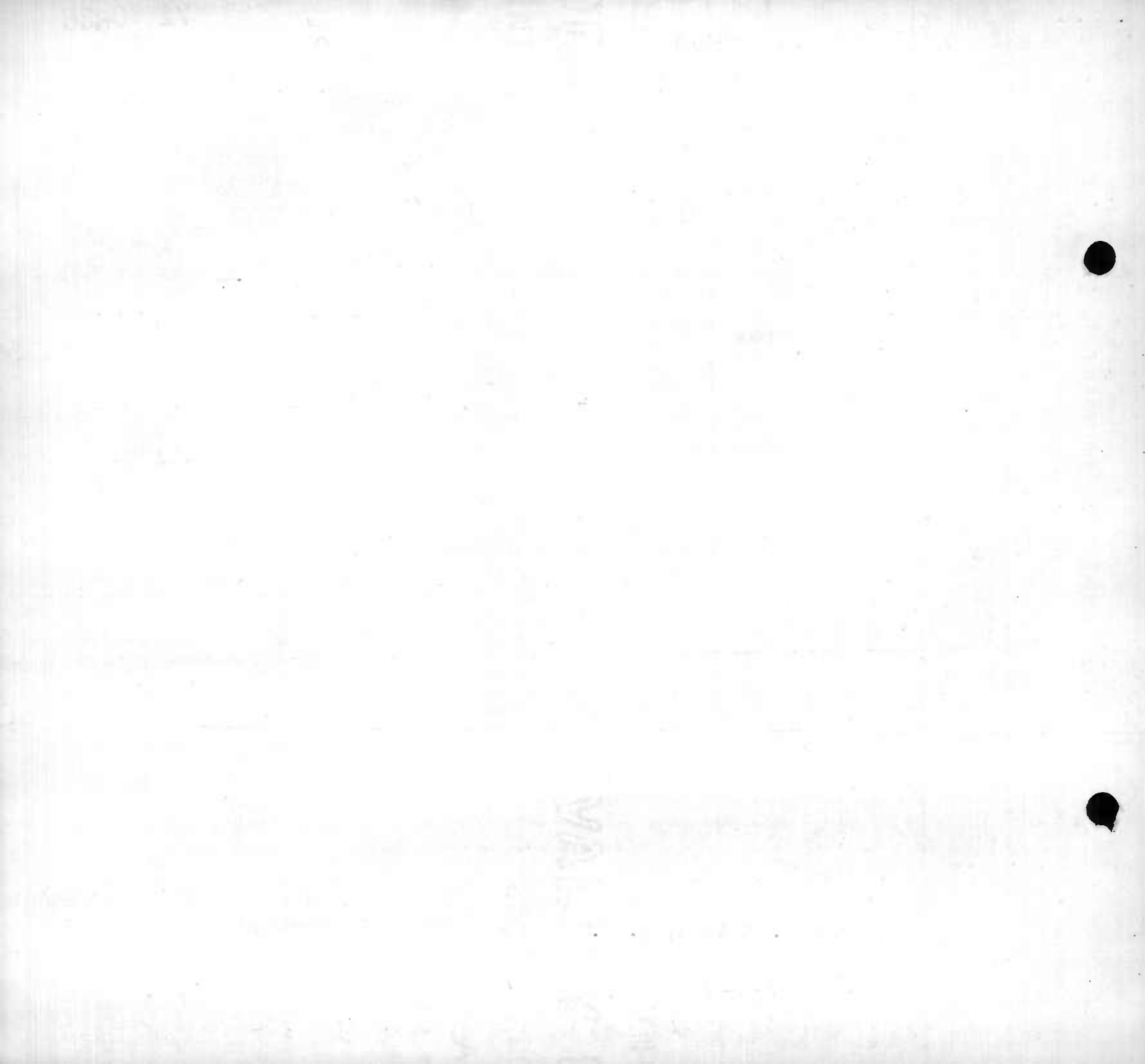
REG. NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Hilda M. Farber Hilda Farber | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 11 71 10:10 p.m. | |
| 6. SEX female | | 7. RACE white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH June 29, 1922 | | 10. AGE (In years last birthday) 48 | |
| 11. BIRTHPLACE (State or foreign country) Mc Keesport, Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 214-20-0578 | |
| 18. INFORMANT Mr. Paul A. Farber, Jr. | | ADDRESS 231 S. Maderia St. | |
| 19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/12/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/15/71 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Sells | |
| 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | | ADDRESS 6500 York Rd. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0636 | |
|---|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> P-150 71 0636 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Katherine Pipino</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>Jan. 18, 1971</i> | | M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>House in the Pines - Belvedere</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | |
| 5. SEX <i>Female</i> | | 6. RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Maker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <i>Sept. 4, 1888</i> | |
| 13. FATHER'S NAME <i>George C. Rammes</i> | | 14. MOTHER'S MAIDEN NAME <i>Barbara Reimer</i> | | 9. AGE (In years last birthday) <i>82</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT ADDRESS <i>Mr. Wilmer Pipino - 702 Old Home Rd. - 21206</i> | |
| 18. <i>410.91</i> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> | | <i>One day</i> | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes - Arteriosclerosis</i> | | <i>2 yrs.</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <i>Urinary Infection</i> | | <i>6 wks.</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 3 1970</i> to <i>Jan 18 1971</i> , that (I) (we) last saw the deceased alive on <i>Jan 11 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Res. Dr. Kolman</i> | | | | 23B. DATE SIGNED <i>1/19/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Lester N. Kolman, M. D.</i> | | | | 23D. ADDRESS <i>6821 Reisterstown Road 21215</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1-21-71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>St. Michael's Lutheran</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Perry Hall, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1971</i> | | | |
| 25B. NAME OF REGISTRAR <i>John C. Miller</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Inc-6415 Belair Rd. - 21206</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------|--|--|--|--|--|---|--|---|--|-------------------------------|--|--|---------------------------------|--|--|--|--|
| 71 0637 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0637 | | | | | | | | | | | | | | |
| BIRTH NO. <u>S-356</u> | | | | | 1. NAME OF DECEASED (Type or Print) <u>Albert Steiner</u> | | | | | 2. DATE AND HOUR OF DEATH <u>January 19, 1971</u> <u>2</u> P.M. | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>6-03</u> | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| <u>414 N. Duncan Street 21231</u> | | | | | E. STREET AND NUMBER <u>#3</u> | | | | | | | | | | | | | | |
| 5. SEX <u>male</u> | | 6. RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 23, 1894</u> | | 9. AGE (In years last birthday) <u>76</u> | | 11. Under 1 Yr. Months: Days | | 12. Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Steel</u> | | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | 13. FATHER'S NAME <u>Vincent Steiner</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Marie Hanzlik</u> | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | | 16. SOCIAL SECURITY NO. <u>216-07-9826</u> | | | | | 17. INFORMANT <u>Mrs. Mary Steiner</u> ADDRESS <u>414 N. Duncan St. 21231</u> | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Thrombosis</u> | | | | | <u>1 day</u> | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | (B) <u>Anterior Arterio Heart disease</u> | | | | | <u>7.</u> | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) _____ | | | | | | | | | | | | | | |
| II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | <u>Colitis - chronic</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> 19 <u>71</u> to <u>1/19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23A. SIGNATURE <u>Louis F. Klimes</u> DEGREE | | | | | 23B. DATE SIGNED <u>1/20/71</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Louis F. Klimes</u> | | | | | 23D. ADDRESS <u>2623 E. Monument Street</u> DEGREE | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | | | | 24B. DATE <u>1/22/71</u> | | | | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | | | | | | | | | |
| 24D. LOCATION (City, town, or county) <u>Baltimore</u> | | | | | 24E. STATE <u>Md.</u> | | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | | | | 25B. NAME OF REGISTRAR <u>Robert E. Talbot</u> | | | | | 25C. FUNERAL DIRECTOR <u>Evach Funeral Homes</u> ADDRESS <u>1211 Chesaco Av. 21237</u> | | | | | | | | | |

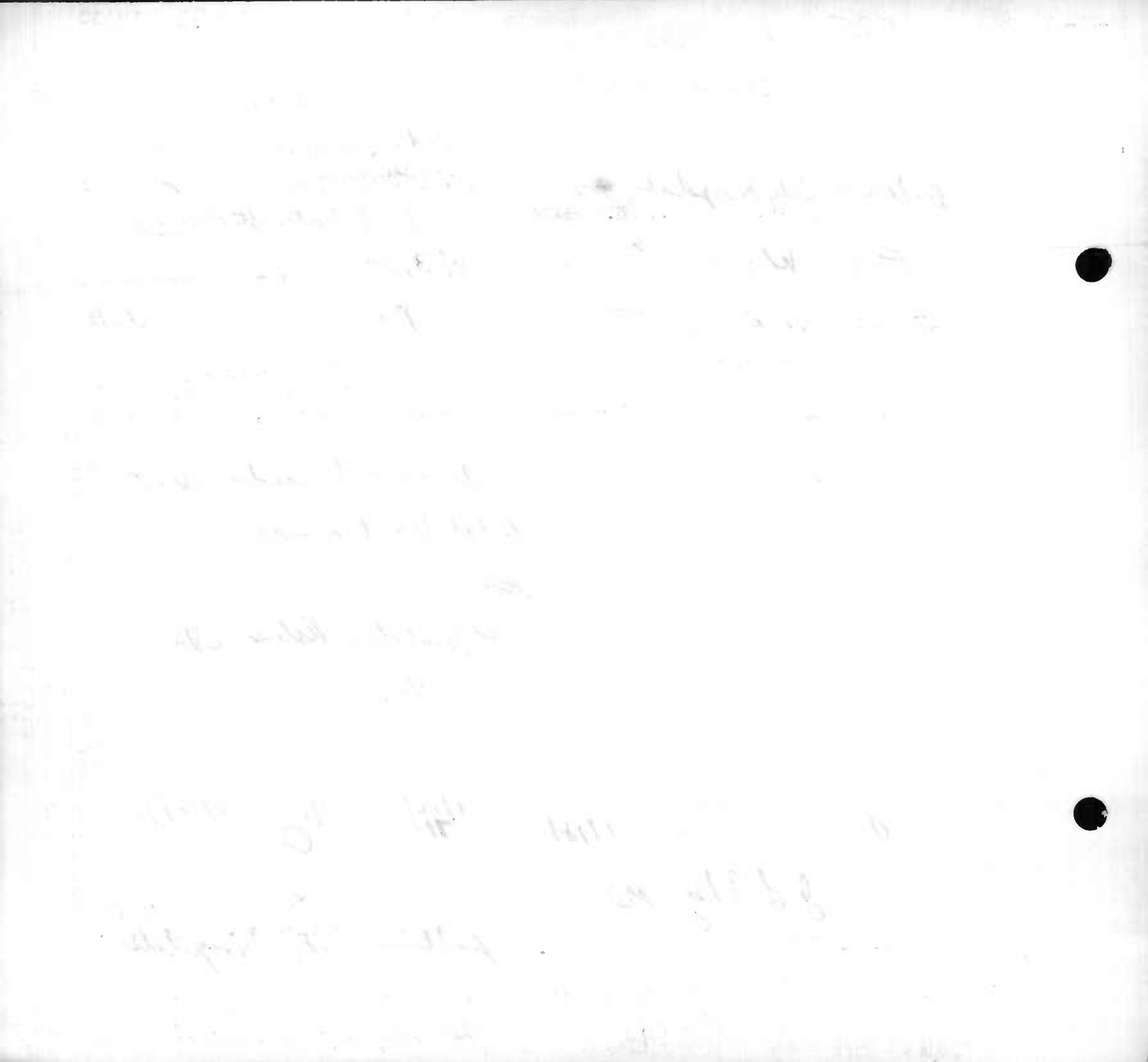
414 N. Duncan St.

71 0638

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|--|--|--|--|--|--|
| J-525 | | 71 0638 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0638 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | REG. NO. | |
| | | Florence E. Johnson | | 1/18/71 9:00 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | Md. | | CARROLL Co 56-27 | |
| Baltimore City Hospital | | 4940 Eastern Ave. Balto., Md. 21224 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | WESTMINSTER | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 91 Liberty St. | | 21157 | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Female | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8/3/04 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSE-WIFE | | — | | PA. | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Clarence Cordell | | Ella MYERS | | NO | | 219-20-1483 | |
| 17. INFORMANT | | 4940 Eastern Avenue ADDRESS | | 17. INFORMANT | | 4940 Eastern Avenue ADDRESS | |
| | | | | ECH-Records Baltimore, Maryland | | 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Anoxia 2' to cardiac arrest 5 min. | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | Bilat. heart mass | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Diabetes mellitus, CVA | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2/2 | | | | Yes | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| I APPROX. | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 1/12/71 | | 1971 to | | 1/18/71 | |
| that (I) (we) last saw the deceased alive on | | 1/18/71 | | 1971 | | and that (in my) (our) opinion death occurred on the date | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | J. L. Fleg MD | | 23B. DATE SIGNED | | 1/18/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | J. L. Fleg | | 23D. ADDRESS | | 4940 Eastern Ave. Balto. Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 1-22-71 | | KRIDERS CEMETERY | | WESTMINSTER MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 21 1971 | | R. E. E. Fleg | | J. S. Myers, Jr. | | Westminster, Md. 21157 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0639 | | CERTIFICATE OF DEATH | | REG. NO. 71 0639 | |
|---|------------------|---|------------------------------|--|----------------------------|--|-----------------------------|---------------------------------------|--|
| BIRTH NO. 8-200 | | | | 1. NAME OF DECEASED (Type or Print) BAESCH, CHARLES | | 2. DATE AND HOUR OF DEATH JANUARY 19, 1971 4:50 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-34 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 25 BRISTOL AVENUE | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 09 22 94 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ROUTE SALESMAN Ice cream | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME RUDOLPH BAESCH | | | | 14. MOTHER'S MAIDEN NAME FREDERICKA () | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO no | | 16. SOCIAL SECURITY NO. 213-05-9645 | | 17. INFORMANT ADDRESS ST AGNES RECORDS-BALTO MD 21229 | | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 14 19 71 to JANUARY 19 19 71 that (I) (we) lost saw the deceased alive on JANUARY 19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Victor Rozenbaum | | | | MD DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1. 19.71 | | | |
| 23C. PHYSICIAN'S NAME (Type) CARLOS VICTOR Rozenbaum | | | | 23D. ADDRESS MD ST Agnes Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1 / 23 / 71 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Md. | | 25C. FUNERAL DIRECTOR McCully - ref 237 Patapasco Ave. | | ADDRESS 21225 | | | |

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S. 220

BALTIMORE CITY HEALTH DEPARTMENT

71 0640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0640

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Marshal Sykes | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 18 71 11:40 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 71 11:40 a.m. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 10. AGE (in years last birthday) 21 | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | E. STREET AND NUMBER 1508 Poplar Grove St. | |
| 12. CITIZEN OF U.S. | | 13. FATHER'S NAME Fred Sykes | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction | | 15. MOTHER'S MAIDEN NAME Willie May Boatwright | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 212-46-0483 | |
| 18. INFORMANT John Boatwright | | ADDRESS | |
| 19. CAUSE OF DEATH E 965X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 21 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) POOL ROOM | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1633 Penna. Avenue | | 22F. HOW DID INJURY OCCUR? Subject was shot during altercation. | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) 1 18 71 11:30 a.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, MD M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/18/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-23-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary | | 24D. LOCATION (City, town, or county) (State) Cedar Hill, Cedar Hill Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Charles Evans Hughes | | ADDRESS 1532 Hollins st. | |

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STANDARD FORM NO. 64

FORM NO. 1

DATE

TO

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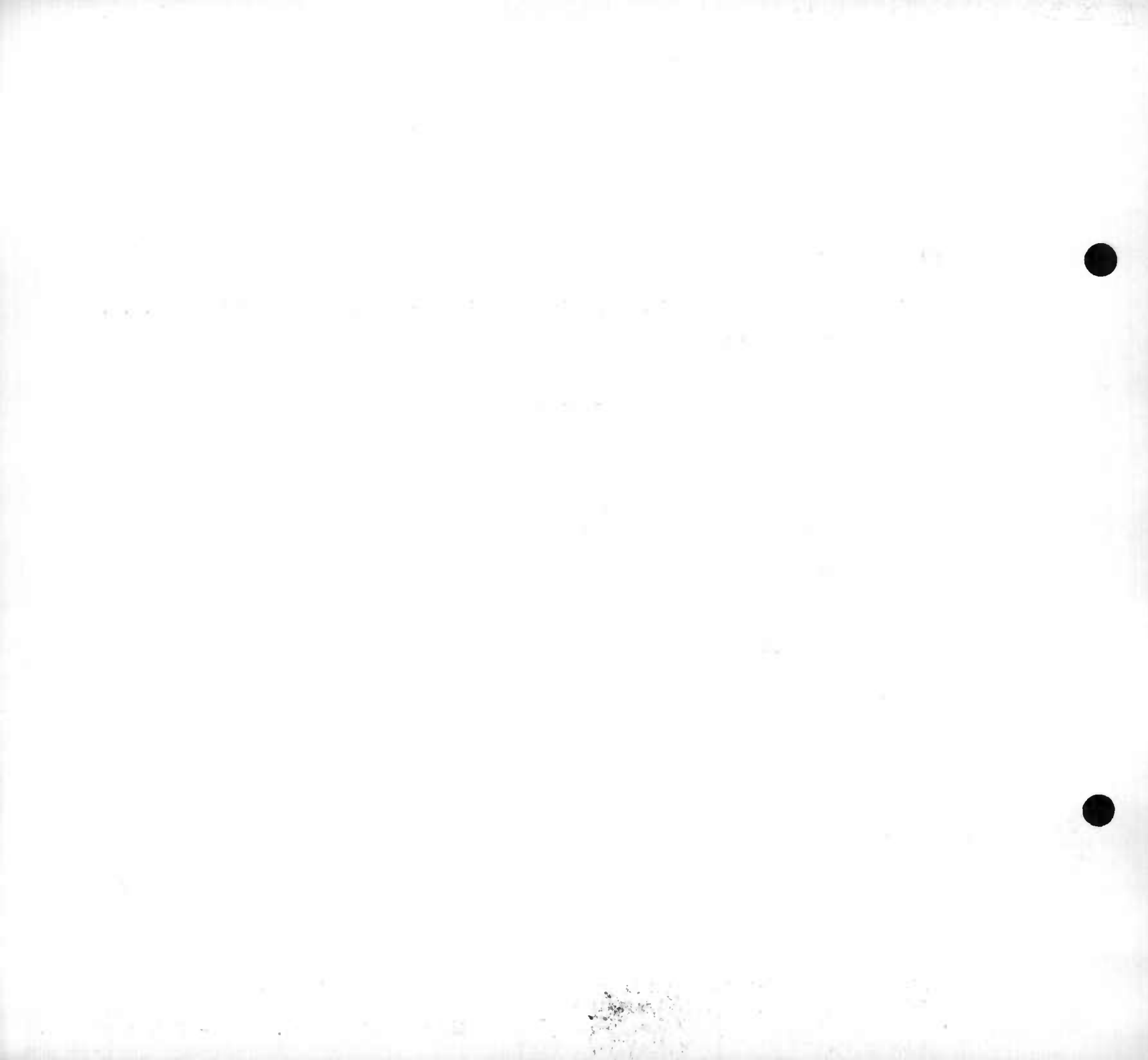
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

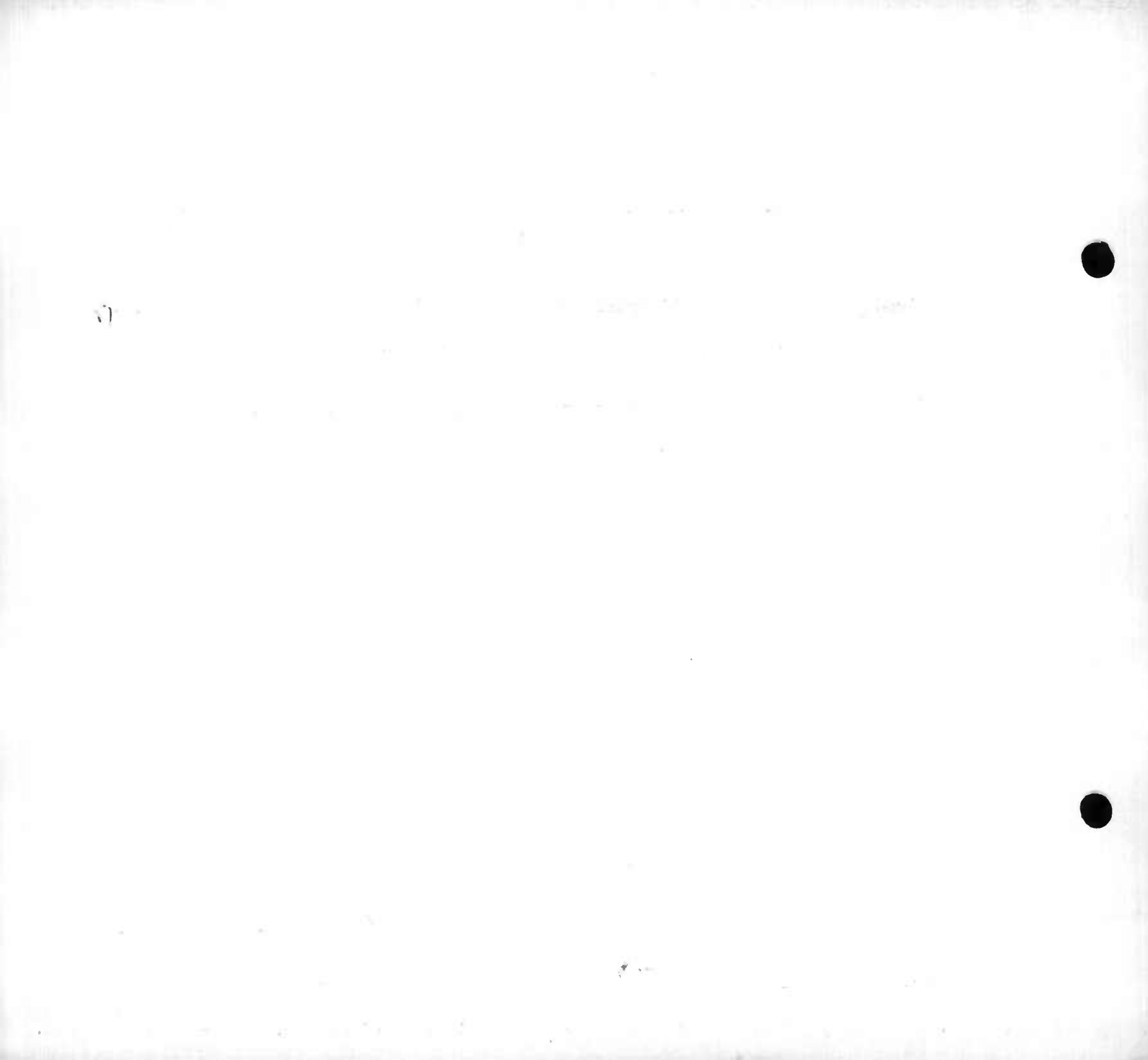
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0641 | |
|---|---|---|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MR. BOLEY LISTICK | | 2. DATE AND HOUR OF DEATH 1/20/71 8:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME A HOSPITAL BALTIMORE, MARYLAND 21231 | | | A. STATE MARYLAND B. COUNTY 2-02 | | |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 307 S. BROADWAY | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/26/04 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY American Standard | | 11. BIRTHPLACE (State or foreign country) Wilkes-Barre, Pennsylvania | |
| 13. FATHER'S NAME STANLEY LISTICK | | | 14. MOTHER'S MAIDEN NAME DOFIELD A | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 195-09-3482 | | 17. INFORMANT JOSEPHINE LISTICK ADDRESS SAME | |
| 18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA, MYOCARDIAL INFARCTION | | |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/1 19 71 to 1/20 19 71 that (I) (we) lost saw the deceased alive on 1/20 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. C. Chouvalit, M.D. | | | | 23B. DATE SIGNED 1/20/71 | |
| 23C. PHYSICIAN'S NAME (Type) A. C. CHOUVALIT M.D. | | | | 23D. ADDRESS CHURCH HOME A HOSPITAL BALTIMORE, MARYLAND 21231 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-25-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. ADDRESS 1901-07 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0642 | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 71 0642 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>McCord, Henry F.</u> | | HENRY F. MCCORD | | 2. DATE AND HOUR OF DEATH <u>1-20-71</u> <u>2:10</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>26-11</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Balto., Md. 21224</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>404 S Bouldin 21224 007</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-10-04</u> | 9. AGE (In years last birthday) <u>66</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Continental Can</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | |
| 13. FATHER'S NAME <u>George McCord</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-03-3795</u> | | 17. INFORMANT <u>BCH-Records</u> | |
| | | | | ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u> | |
| 18. <u>162.1 I</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic CA of lung</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-21</u> 19 <u>70</u> to <u>1-20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1-20-</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Sonia Estruch M.D.</u> DEGREE | | | | 23B. DATE SIGNED <u>Jan. 20-1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Sonia Estruch M.D.</u> DEGREE | | | | 23D. ADDRESS <u>4940 Eastern Ave. Balto., Md. 21224</u> <u>BALTIMORE CITY HOSP.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-23-1971</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | 25B. NAME OF REGISTRAR <u>James E. Farber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc.</u> | |
| | | | | ADDRESS <u>1901-07 Eastern Ave.</u> | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0643 | | | |
|---|--|-------------------------------------|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. 7-630 71 0643 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) CORNELIUS J. FORD | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3733 Eastern Ave. 2nd floor | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 16 1971 3:35 PM | | | |
| | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 26-09 | | | |
| 6. SEX male | | 7. RACE white | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH July 8, 1920 | | 10. AGE (In years last birthday) 50 | | 11 Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER 3733 Eastern Ave. 2nd floor | |
| 11. BIRTHPLACE (State or foreign country) Tennessee | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME ? Ford | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Jane | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | | | 17. SOCIAL SECURITY NO. 408-22-8610 | | 18. INFORMANT Mrs Margaret Klock ADDRESS 3337 Elmley Avenue | |
| 19. 571.0 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Fatty Liver DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (C) | | | |
| 20A. DATE OF OPERATION 2/1 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | | | DATE SIGNED 1-17-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-21-1971 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross | | 24D. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave. | |

Letter from M.E.'s office

1-26-71

M.H.

ACADEMY BOND

WALLEY PAPER CO
U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0644 | |
|--|--|---|---|--|--|
| BIRTH NO. W-452 71 0644 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Josephine Williams | | | 2. DATE AND HOUR OF DEATH 1-18-71 7AM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MT. Sinai Nursing Home | | | A. STATE MD. | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4613 Park Heights Ave. | | | B. COUNTY 15-11 | | |
| 5. SEX Female | | | 6. RACE Negro | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 4-29-90 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 11. BIRTHPLACE (State or foreign country) Kent Island, Maryland | | |
| 13. FATHER'S NAME James Sewell | | | 14. MOTHER'S MAIDEN NAME Mary Watkins | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 215-14-9145 | | |
| 17. INFORMANT Catherine Woods, 3902 Hilton Rd. Apt 153 | | | ADDRESS 3902 Hilton Road Apt 153 | | |
| 18. 4/12/41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD & CVA's (x2) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive Heart Failure | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/18/68 to 11/17/71 that (I) (we) last saw the deceased alive on 1/15/71 and that (in my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Elijah Saunders, MD | | | 23B. DATE SIGNED 1/18/71 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Donald W. Stewart | | | 23D. ADDRESS 2300 Garrison Blvd. Balto. Md. 21216 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/21/71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, No. | | 25C. FUNERAL DIRECTOR Kenneth H. Law | | | |
| 25D. ADDRESS 4609 Park Heights. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

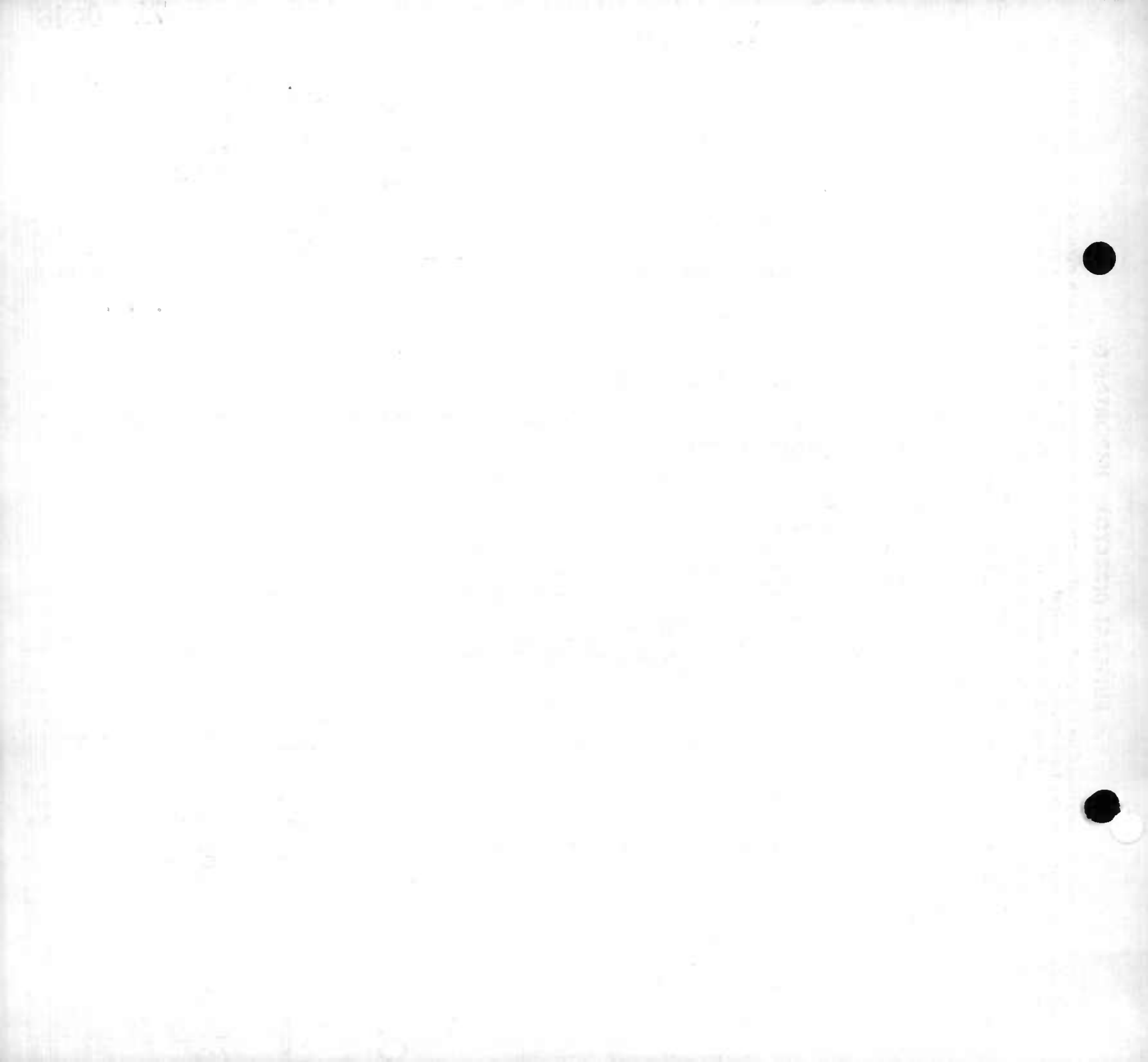
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0645 | |
|--|--|--|--|--|--|
| BIRTH NO. L-400 | | 0645 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) (ANN ELIZABETH LILLY) | | | 2. DATE AND HOUR OF DEATH 1-20-71 2:15 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | | C. CITY OR TOWN Baltimore 21218 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 9-15-92 9. AGE (In years last birthday) 78 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, retired Md. State |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William Lilly | | | 14. MOTHER'S MAIDEN NAME Rebecca Le Brun | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 219-36-1539 A | | 17. INFORMANT Mrs. Evelyn Keller ADDRESS 1530 Balworth Rd. Baltimore Md. 21218 |
| 18. 676.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: gastrointestinal perforation due to ulcer | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: pelvic abscess | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1-21 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-21 19 70 to 1-20 19 71 that (I) (we) last saw the deceased alive on 1-20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. O. NAPIZA | | | | 23B. DATE SIGNED 1-20-71 | |
| 23C. PHYSICIAN'S NAME (Type) MARIELY NAPIZA | | | | 23D. ADDRESS Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Jan. 23, 1971 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore Md. | | 24E. NAME of REGISTRAR HENRY SANDER & SONS, INC. | | 24F. ADDRESS Baltimore Md. | |
| 25A. DATE RECD BY HEALTH DEPT. JAN 21 1971 25B. NAME OF REGISTRAR HENRY SANDER & SONS, INC. 25C. FUNERAL DIRECTOR Baltimore Md. | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0646 | |
|---|--|---|---|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Lenora Cason | | | | 2. DATE AND HOUR OF DEATH Jan. 20, 1971 8:30 AM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 13-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 821 Brooks Lane | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-12-58 | 9. AGE (In years last birthday) 12 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | 10B. KIND OF BUSINESS OR INDUSTRY Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Russell Cason | | | 14. MOTHER'S MAIDEN NAME Shirley Cook | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Shirley Cason ADDRESS same | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Hepatic Coma DUE TO, OR AS A CONSEQUENCE OF: (C) Acute Hepatic Necrosis </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2/ | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Aziz, M.D. | | | | 23B. DATE SIGNED 1-20-71 | |
| 23C. PHYSICIAN'S NAME (Type) S. Aziz, M.D. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10-25-71 | | 24C. NAME of CEMETERY or CREMATORY New Gatheral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | | |
| 25B. NAME OF FUNERAL DIRECTOR Eleanor J. Bland | | 25C. ADDRESS 1347 N. Calhoun | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 0647

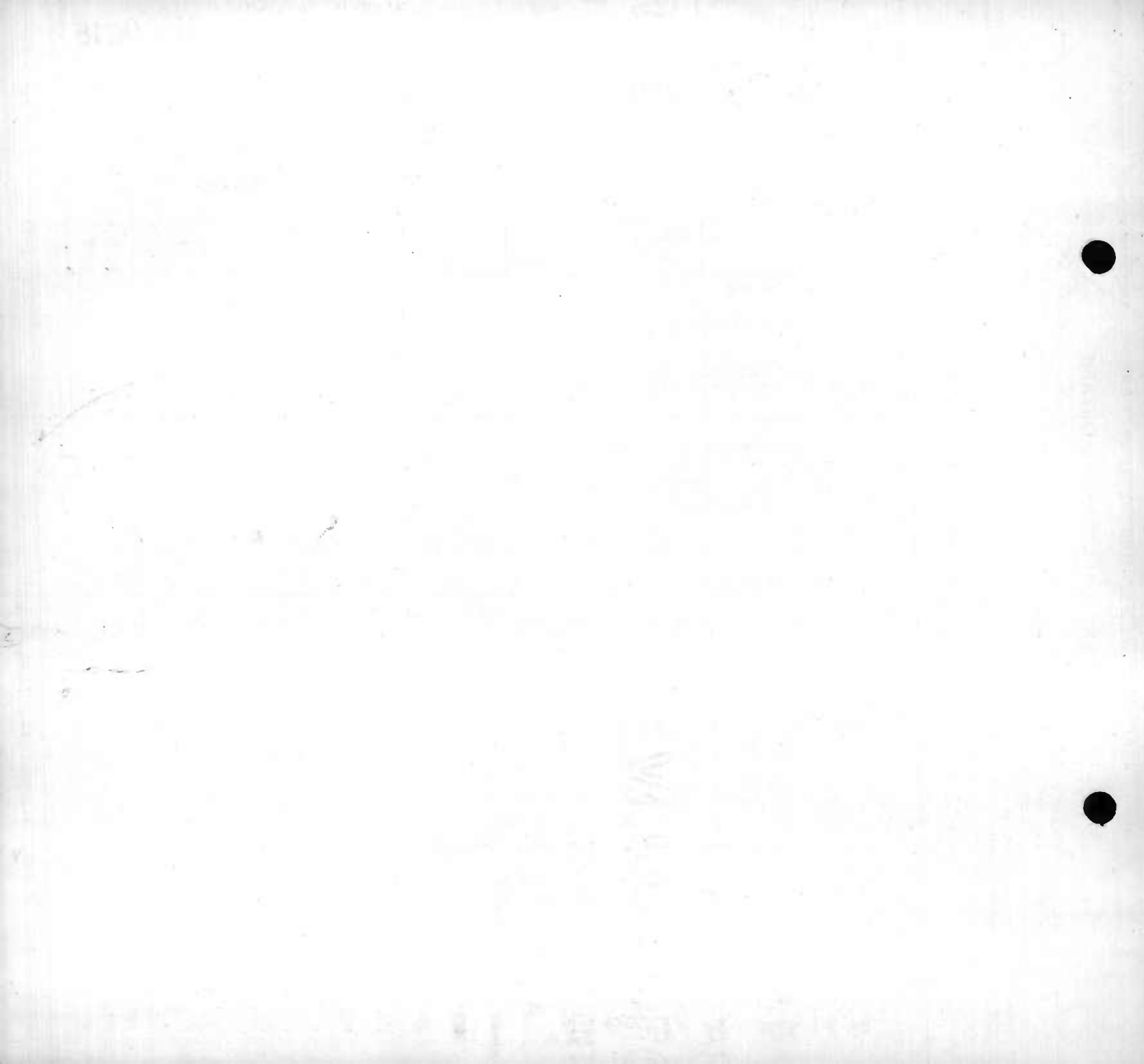
| | | | |
|---|---------------|--|--------------------------|
| BIRTH NO. 71 0647 | | 2. DATE AND HOUR OF DEATH 1/20/71 1:45 P | |
| 1. NAME OF DECEASED (Type or Print) LEROY RICHARDSON | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-01 | |
| 3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital | | E. STREET AND NUMBER 1548 WOODYEAR ST. | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/23/02 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME BEN | | 14. MOTHER'S MAIDEN NAME THERESA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT UNKNOWN | | ADDRESS | |
| 18. 1971.0 I CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA in lungs -> | | UNKNOWN | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last (B) Right sided Broncho-pneumonia | | 2 WEEKS | |
| (C) Electrolyte Imbalance | | 2 WEEKS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 1/5/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (P) PLEURAL EFFUSION | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/31 1970 to 1/20 1971 that (I) (we) last saw the deceased alive on 1/20 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE C. L. Cromwell, MD | | 23B. DATE SIGNED 1/20/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/23/71 | |
| 24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A A County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Fahey, M.D. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| A Halstead | | 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 71 0648 | |
|---|-------------------------|--|------------------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) Elizabeth MARY CLARK | | 2. DATE AND HOUR OF DEATH 13 JANUARY 1971 2:55 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 12-05 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 401 E. Federal Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/15/81 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME John Jones | | 14. MOTHER'S MAIDEN NAME Mary Jones | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Virginia Harrison 401 E. Federal St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 436.914-174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH STROKE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). BREAST CANCER, URINARY TRACT INF. | | 20. AUTOPSY? (Yes or No) No | | 21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9 JAN 1971 to 13 JAN 1971 , that (1) (we) last saw the deceased alive on 13 JAN 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Benjamin J. Portnoy M.D. | | 23B. DATE SIGNED 13 Jan. 1971 | | 23C. PHYSICIAN'S NAME (Type) Benjamin Portnoy, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-21-71 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) A.A. Co., Maryland | | 24E. FUNERAL DIRECTOR 1735 Harford Ave. 21213 | | 24F. ADDRESS Marshall W. Jones, Jr. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0649</u> | |
|---|-------------------------|---|---|--|--|
| BIRTH NO. <u>71 0649</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>CHARLOTTE GOLDIE WRIGHT COLEMAN</u> | | | 2. DATE AND HOUR OF DEATH <u>1/19/71</u> <u>12 noon</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital</u> <u>Belvedere & Greenspring Aves.</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>9-06</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1701 East 31st Street</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-7-20</u> | 9. AGE (In years last birthday) <u>50</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>unk</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Sarah</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS <u>Mr. James Wright 1701 E. 31st St. 21218</u> | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of breast</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>174X I</u> <u>Cancer of breast</u> <u>4 yrs</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> | | |
| MEDICAL CERTIFICATION | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>1967</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cancer of left breast</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>Jan 19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Aug 19</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Louis H Schaffer, MD</u> | | | | 23B. DATE SIGNED <u>1/19/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Louis H Schaffer, MD</u> | | | | 23D. ADDRESS <u>3241 722 W Wood Spring Lane Baltimore, Md 21210</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1-23-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>James E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Marshall W. Jones, Jr.</u> | | | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **71 0650**

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) CLIFTON MACK | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 20, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 20, 1971 10:30 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-05 | |
| 9. DATE OF BIRTH 2/20/40 | | 10. AGE (In years lost birthday) 30 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Clifton Mack Sr. | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk | |
| 15. MOTHER'S MAIDEN NAME Carrie Singleton | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/18/63 to 1969 | |
| 17. SOCIAL SECURITY NO. 212-36-2406 | | 18. INFORMANT ADDRESS Carrie Jackson 118 Cherry Hill Rd. | |
| 19. E 966X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Stabwounds of chest and back DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) Yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Parking Lot | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 210 St. Paul St. | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1-20-71 10:00 P.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? Stabbed during altercation | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED January 21, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Charles A. Rice | | ADDRESS 661 W. Barre St. | |

0520

0530

VALLEY PARK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

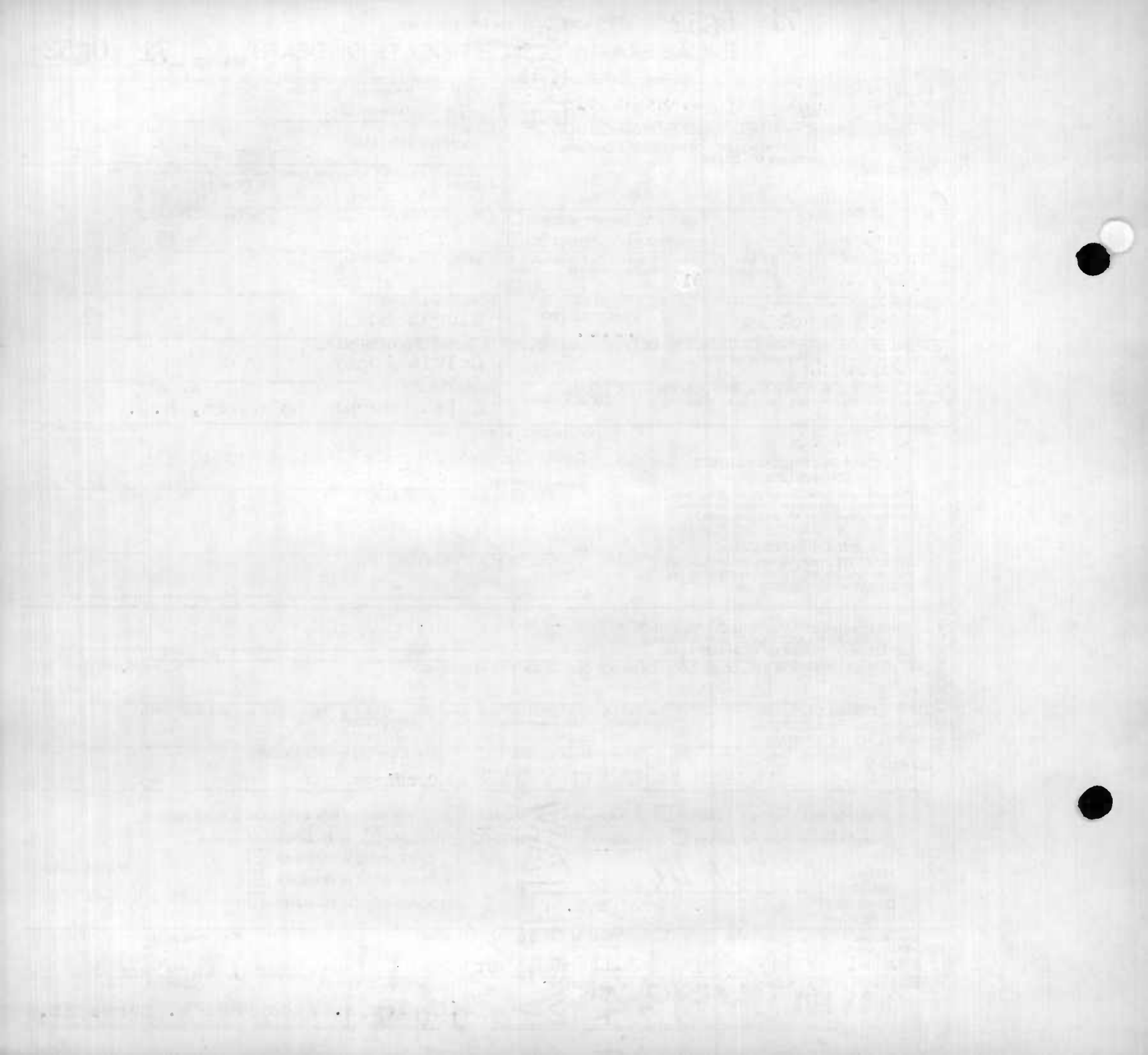
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0651 |
|--|--|---|---|---|
| BIRTH NO. B-622 | | 71 0651 | | |
| 1. NAME OF DECEASED (Type or Print) Burgess, Ella V. | | 2. DATE AND HOUR OF DEATH 1/18/71 11:15 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University of Md. Hosp. 22 S. Greene St 2/201 | | A. STATE Maryland B. COUNTY 21-01 | | |
| | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER 653 Portland St. | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/3/00 | 9. AGE (In years last birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY USA. | | 13. FATHER'S NAME Joseph Brown | | |
| 14. MOTHER'S MAIDEN NAME Ella V. Barnett | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | |
| 16. SOCIAL SECURITY NO. 213-30-6675 | | 17. INFORMANT John Brown 653 Portland St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 410.91 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION 48 HRS. DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) CONGESTIVE HEART FAILURE 48 HRS. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 1-17-71 19 71 to 1-18 19 71 that (I) (we) last saw the deceased alive on 1-18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Jaime F. Casellas | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-18-71 |
| 23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS | | 23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 1-23-71 | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | 25B. NAME OF REGISTRAR Charles A. Rice | 25C. FUNERAL DIRECTOR ADDRESS 661 W. BARRE ST. | | |



71 0652 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **71 0652**

BIRTH NO.

| | | | |
|---|-------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) HATTIE ROACH or Hettie | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. 3. DATE PRONOUNCED DEAD Month Day Year Hour January 13, 1971 10:45 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 644 Dover Street | | 5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE Maryland B. COUNTY 21-01 | |
| 6. SEX Female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. DATE OF BIRTH 3/16/99 |
| 10. AGE (In years lost birthday) 71 | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Claude Bunch | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 15. MOTHER'S MAIDEN NAME Sylvia Rpper | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. Beulah Berrus Belhaven, N.C. | |
| 19. E 890X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Smoke and soot inhalation incident to conflagration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fatty metamorphosis of Liver | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 644 Dover Street 21-01 | |
| 22D. TIME OF INJURY (APPROX.) 1-12 or 13, 1970 ? m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? Conflagration | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 1/13/71 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 1/18/71 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| R-220 | | 71 0653 | | Baltimore City Health Department | | REG. NO. | | 71 0653 | |
|--|--|---------|--|--|--|----------|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE | | | | B. COUNTY | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | C. CITY OR TOWN | | | | D. INSIDE CITY LIMITS? | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | E. STREET AND NUMBER | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from | | | | 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | | | 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR ADDRESS | | | | 25D. NAME OF REGISTRAR | | | | 25E. FUNERAL DIRECTOR ADDRESS | |



| | | | | |
|--|--|---|---|---|
| 1. NAME OF DECEASED (Type or Print) WILLIAM B. LACHER | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 20, 1971 | | Hour 7:00 P.M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year January 20, 1971 | | Hour 7:00 P.M. |
| 6. SEX Male | | 7. RACE White | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 12/23/1952 | | 10. AGE (In years lost birthday) 18 | C. CITY OR TOWN Baltimore | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 14B. KIND OF BUSINESS OR INDUSTRY Education | | E. STREET AND NUMBER 824 Loyola Drive |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 215-50-8229 | | 15. MOTHER'S MAIDEN NAME Katharine Gilbert |
| 18. INFORMANT Rev. E. Lawrence Lacher | | ADDRESS (Same) | | |
| 19. E 812.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Rt. #2 South of Meadowridge Road |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1-20-71 4:30 P.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Driver on motorcycle struck by auto |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 21, 1971 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/23/71 | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | 24D. LOCATION (City, town, or county) (State) Baltimore Md. |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR N 869 0 | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212 |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0655</u> | |
|---|---------------------|---|---------------------------------------|---|---|
| <div style="display: flex; justify-content: space-between;"> 15-430 71 0655 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mrs. Margaret Ford Belt</u> | | 2. DATE AND HOUR OF DEATH <u>January 21, 1971</u> <u>17:50 a.m.</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick Home for Incurables</u> | | A. STATE <u>Maryland</u> | | B. COUNTY <u>27-13</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>4 Beechdale Road</u> | | | |
| 5. SEX <u>female</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-22-1894</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Raymond G. Ford</u> | | 14. MOTHER'S MAIDEN NAME <u>Mattie B. Keller</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>212-01-8121</u> <u>219-32-0622</u> | | 17. INFORMANT <u>D Keswick Records</u> | |
| | | ADDRESS <u>700 W. 40th St.</u> | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>Cerebral Arteriosclerosis</u></p> <p>(B) <u>ASCVD with Cerebral Thrombosis</u></p> <p>(C) _____</p> </div> <div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>2 yrs.</u></p> <p><u>4 yrs</u></p> </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>22 Oct</u> 19 <u>68</u> to <u>21 Jan</u> 19 <u>71</u> | | | | | |
| that (I) (we) last saw the deceased alive on <u>21 Jan</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Aubrey D. Richardson M.D.</u> | | 23B. DATE SIGNED <u>21 Jan 1971</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Aubrey Richardson, M.D.</u> | |
| 23D. ADDRESS <u>700 West 40th Street</u> | | 23E. PHYSICIAN'S DEGREE <u>DEGREE</u> | | 23F. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/23/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | |
| 24D. LOCATION <u>Baltimore</u> | | 24E. STATE <u>Md.</u> | | 24F. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1971</u> | |
| 24G. NAME OF REGISTRAR <u>Robert E. Bailey, Md.</u> | | 24H. NAME OF REGISTRAR <u>0 0 0</u> | | 24I. FUNERAL DIRECTOR <u>H. Jenkins & Sons Co.</u> | |
| 24J. ADDRESS <u>4905 York Rd.</u> | | 24K. CITY <u>Balto., Md.</u> | | 24L. ZIP CODE <u>21212</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0656</u> | |
|--|---------|--|--------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| BABY GIRL MOODY | | 1-20-71 | | 8.30 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| | | MARYLAND | | BALTIMORE CITY | |
| 3 THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 2731 E. BIDDLE STREET | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| FEMALE | NEGRO | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-20-71 | --- | 4 47 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JERRY MOODY | | | DESIREE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p style="text-align: center;">I</p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>(A) IMMEDIATE CAUSE <u>Hypertensive member disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>6 hours</u></p> <p>(B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: <u>6 hours</u></p> <p>(C) _____</p> </div> </div> | | | | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | NO | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>71</u> to <u>1/20</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>1/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <u>Dianne S. Elfendin MD</u> | | | | 1/20/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| DIANNE S. ELFENBEIN | | | | THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Cremation | | 1/21/71 | | Johns Hopkins Hospital | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | 601 N Broadway Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 21 1971 | | [Signature] | | HOSPITAL DISPOSAL | |



D-620 71 0657

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0657

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HENRY DRAKE

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

00 118 N. Amity St.

Md.

18-01

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Dec. 16/1925

10. AGE (In years
last birthday)

45

Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

118 N. Amity St.

11. BIRTHPLACE (State or foreign country)

Halifax N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Drake

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Carrie Bridgett

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Josephine Drake 118 N. Amity St.

19. 4124

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan. 23, 1971

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1971

25B. NAME OF REGISTRAR

R. E. F. F. F.

25C. FUNERAL DIRECTOR

William F. F. F.

ADDRESS

319 N. Schrock St.

Dec. 11/07
Hollis M.C.
Lapner
10

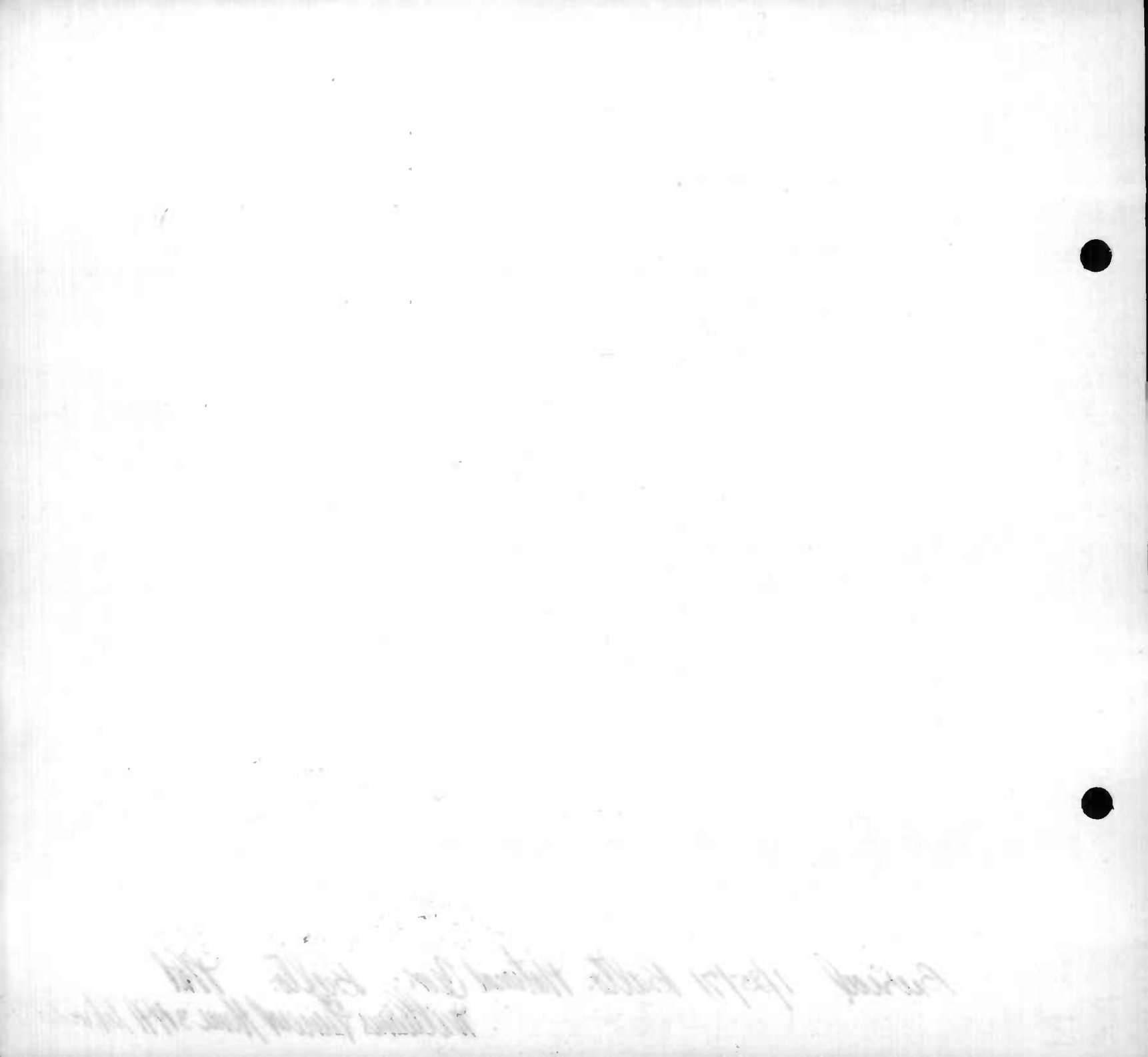
Josephine Drake
Cora Pitts
Harry Drake

General Treasurer W. H. Drake
William Drake
100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0658 | |
|---|---------------------------|---|---|--|---|
| T-600 71 0658 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Mary Moulton Terry | | Jan. 19, 1971 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1083 W. Fayette St. | | | A. STATE Md. | | |
| | | | B. COUNTY | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1083 W. Fayette St. | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 2, 1908 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME Charles Moulton | | | 14. MOTHER'S MAIDEN NAME Bettie Ransom | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 218-18-1598 | | 17. INFORMANT Rebecca Fisher | |
| | | | | ADDRESS 1089 W. Fayette St | |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary vascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-26-1971 to 1-19-1971 , that (I) (we) last saw the deceased alive on 1-16-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William H. W. [Signature] | | | | 23B. DATE SIGNED 1/21/71 | |
| 23C. PHYSICIAN'S NAME (Type) W. H. M. [Signature] | | | | 23D. ADDRESS 515 N. [Signature] | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1/25/71 | | Balto. National Cem. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR [Signature] | |
| | | | | ADDRESS Home 3198 Schroeder St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

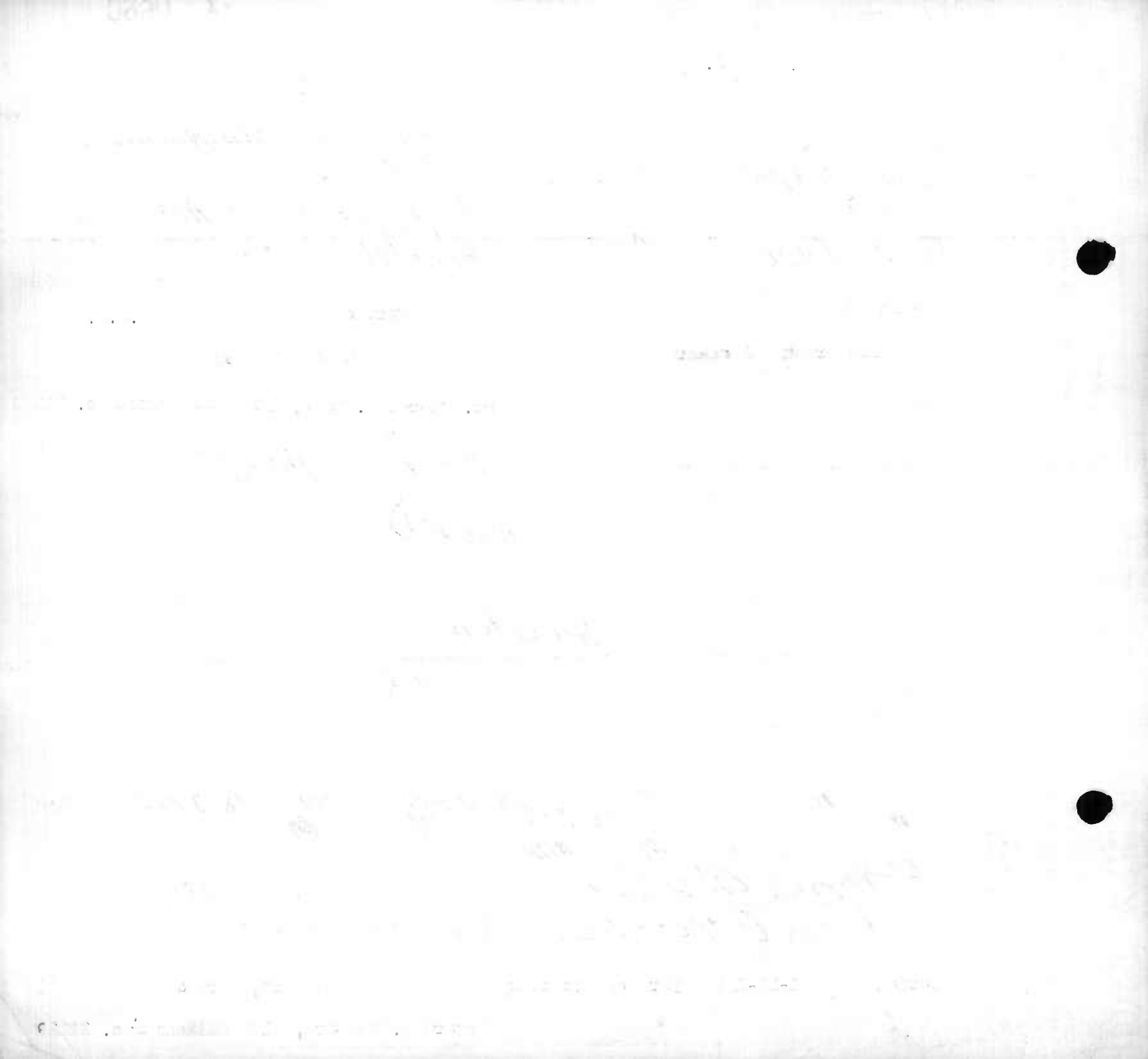
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0659 | |
|--|---|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> G-200 71 0659 </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. 71-01216 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Gough | | | 2. DATE AND HOUR OF DEATH 1-15-71 7:30 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY — | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 2307 Avalon Ave | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-15-71 7:15 AM | 9. AGE (In years last birthday) 0 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. 15 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Steven Early, Jr. | | | 14. MOTHER'S MAIDEN NAME Eleanor Virginia Gough | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS — |
| <div style="display: flex;"> <div style="flex: 1;"> <p>18. 777X1 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE Prematurity (2168oz) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Born at home (DOA) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) —</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min</p> </div> </div> | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | | | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| <p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-15-71 19 71 to 1-15 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-15-71 19 71 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.</p> | | | | | |
| 23A. SIGNATURE P. Roberts, MD | | | 23B. DATE SIGNED 1-18-71 | | |
| 23C. PHYSICIAN'S NAME (Type) P. Roberts | | | 23D. ADDRESS Provident Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 1-19-71 | | 24B. DATE 1-19-71 | | 24C. NAME OF CEMETERY or CREMATORY — | |
| 24D. LOCATION (City, town, or county) — | | 24E. LOCATION (State) — | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 21 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR — | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

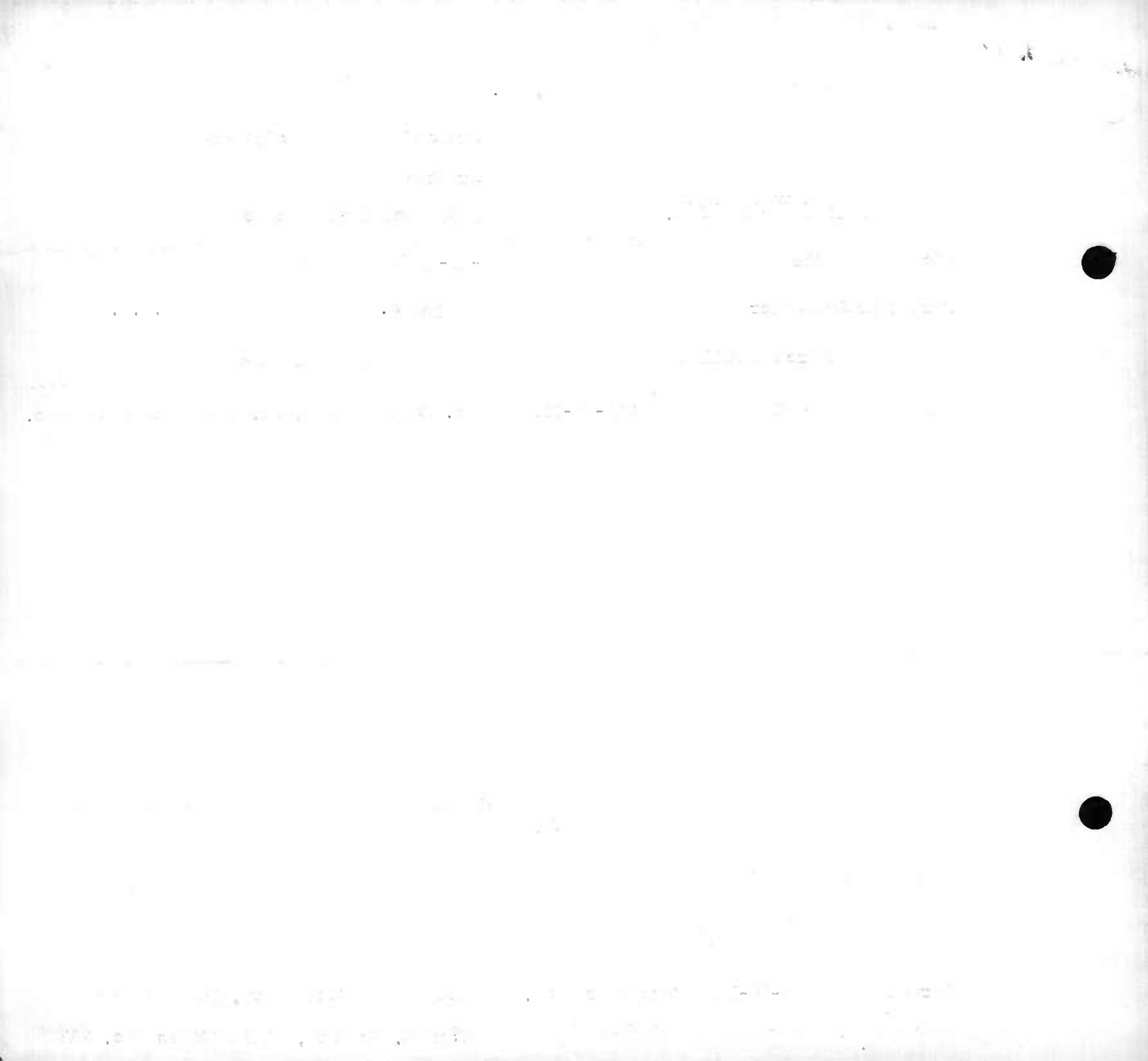
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|-------------------------------|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> L-500 71 0660 71 0660 </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>A/ma LANE</i> | | | 2. DATE AND HOUR OF DEATH <i>18 JANUARY 1971</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>XXXXXXX</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i> <i>42</i> | | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER <i>1925 Breitwert Ave. 25-53</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Cave</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>2/22/91</i> | 9. AGE (In years last birthday) <i>79</i> | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Frederick Anacker</i> | | 14. MOTHER'S MAIDEN NAME <i>Emma Becker</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Mr. George R. Lane, 1925 Breitwert Ave. 21230</i> | |
| 18. <i>412.4 & 174X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH <i>Gordio-Pulmonary Arrest</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCD</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Breaster</i> | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>my</i> (this hospital) attended the deceased from <i>18 JAN</i> 19 <i>71</i> to <i>18 JAN</i> 19 <i>71</i> that <i>my</i> (we) last saw the deceased alive on <i>18 JAN</i> 19 <i>71</i> and that <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>my</i> (we) (did) <i>not</i> view the body after death. | | | | | |
| 23A. SIGNATURE <i>Mona Abelfin</i> | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>18 JAN 71</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>MORRIS Costello, MD</i> | | | 23D. ADDRESS <i>Sinai Hospital of Baltimore</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE <i>1-21-1971</i> | 24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Kelley</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0661</u> |
|--|-------------------------|---|--------------------------------------|--|
| BIRTH NO. <u>F-450</u> | | 71 0661 | | |
| 1. NAME OF DECEASED (Type or Print) <u>JAMES A. FALLON, SR.</u> | | 2. DATE AND HOUR OF DEATH <u>1/17/1971</u> <u>1:45 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Hood Nursing Home</u> <u>5313 Edmondson Ave.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Arbutus</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1039 Beechfield Avenue</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-16-1897</u> | 9. AGE (In years last birthday) <u>73</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Assembler</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Penn^a.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Lawrence Fallon</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Ellen Polemen</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>WWI</u> | | |
| 16. SOCIAL SECURITY NO. <u>215-09-3359 A</u> | | 17. INFORMANT <u>Mr. James Fallon, Jr. 1039 Beechfield Ave.</u> | | |
| 18. <u>41019 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute MI</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASHD</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u> <u>Years.</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic Obstructive Lung Disease</u> | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/16/1968</u> to <u>1/17/71</u> that (I) (we) last saw the deceased alive on <u>1/13/1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Don Ammer</u> | | 23B. DATE SIGNED <u>1/17/1971</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Adrian M. Sonmez</u> | | 23D. ADDRESS <u>1011 Frederick Rd. Beach Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-20-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Gettysburg Nat. Cemetery</u> |
| 24D. LOCATION <u>Gettysburg, Pennsylvania</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Gable</u> | | 25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> | | |
| 25D. ADDRESS <u>4107 Wilkens Ave. 21229</u> | | | | |



FUNERAL DIRECTOR: IMPORTANT

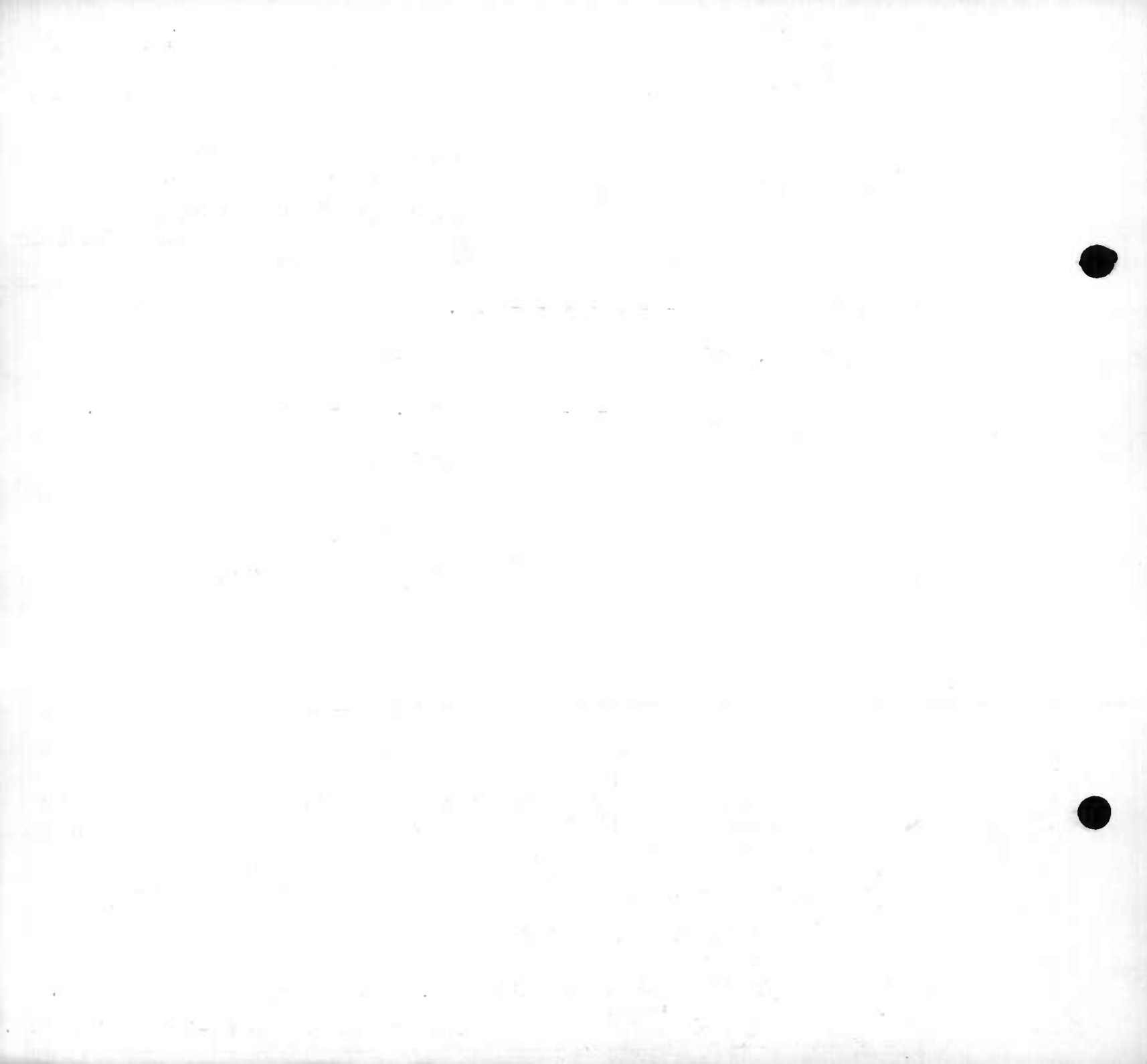
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0662</u> | |
|--|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. <u>R-453</u> | | 71 0662 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ROLLAND, CARLTON ELMER | | 2. DATE AND HOUR OF DEATH JANUARY 19, 1971 1:40A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 1008 ELM RD. | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 08 22 05 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE | | 10B. KIND OF BUSINESS OR INDUSTRY First Nat. Bank | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 13. FATHER'S NAME CARL ROLLAND | | 14. MOTHER'S MAIDEN NAME CORA (MERDIN) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215074418 | | 17. INFORMANT WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON & | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE MI & CARDIOGENIC SHOCK | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 15 19 71 to JANUARY 19 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JANUARY 19 19 71 and that <input checked="" type="checkbox"/> (my) (our) apintan death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE Ching Hui Tsai, M.D. | | DEGREE | | 23B. DATE SIGNED 1/19/71 | |
| 23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai, M.D. | | DEGREE | | 23D. ADDRESS CATON & WILKENS AVES. BALTO-MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-22-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 23 1971 | | 25B. NAME OF REGISTRAR John E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | |
| ADDRESS 4107 Wilkens Ave. 21229 | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0663</u> |
|--|---------------------|---|------------------------------------|---|
| L-100 <u>71 0663</u> | | CERTIFICATE OF DEATH | | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH <u>1/21/71</u> <u>7:15 A.M.</u> | | |
| 1. NAME OF DECEASED (Type or Print) <u>DOROTHY LEAF</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>42 SINAI HOSP. OF BALTO.</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. OF BALTO.</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>27-55</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER <u>5518 MATTFELDT AVE.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/18/08</u> | 9. AGE (In years last birthday) <u>62</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY - - - - - | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>William S. O'Neil</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Elsie Lucas</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>216-32-4964</u> | | 17. INFORMANT ADDRESS <u>Harry H. Leaf-5518 Mattfeldt Ave.</u> | | |
| 18. CAUSE OF DEATH <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>MI</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u> (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> 19 <u>71</u> to <u>1/21</u> 19 <u>71</u> and that (we) lost saw the deceased alive on <u>1/21</u> 19 <u>71</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. <u>(We) (did) (did not)</u> view the body after death. | | | | |
| 23A. SIGNATURE <u>Fortunato V. Eliazzi M.D.</u> | | | | 23B. DATE SIGNED <u>1/21/71</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>FORTUNATO V. ELIAZZI</u> | | | | 23D. ADDRESS <u>Donovan Funeral Home -3818 Roland Ave.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/25/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u> |
| 24D. LOCATION <u>Baltimore</u> | | 24E. (City, town, or county) (State) <u>Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>Rebecca Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Donovan Funeral Home</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

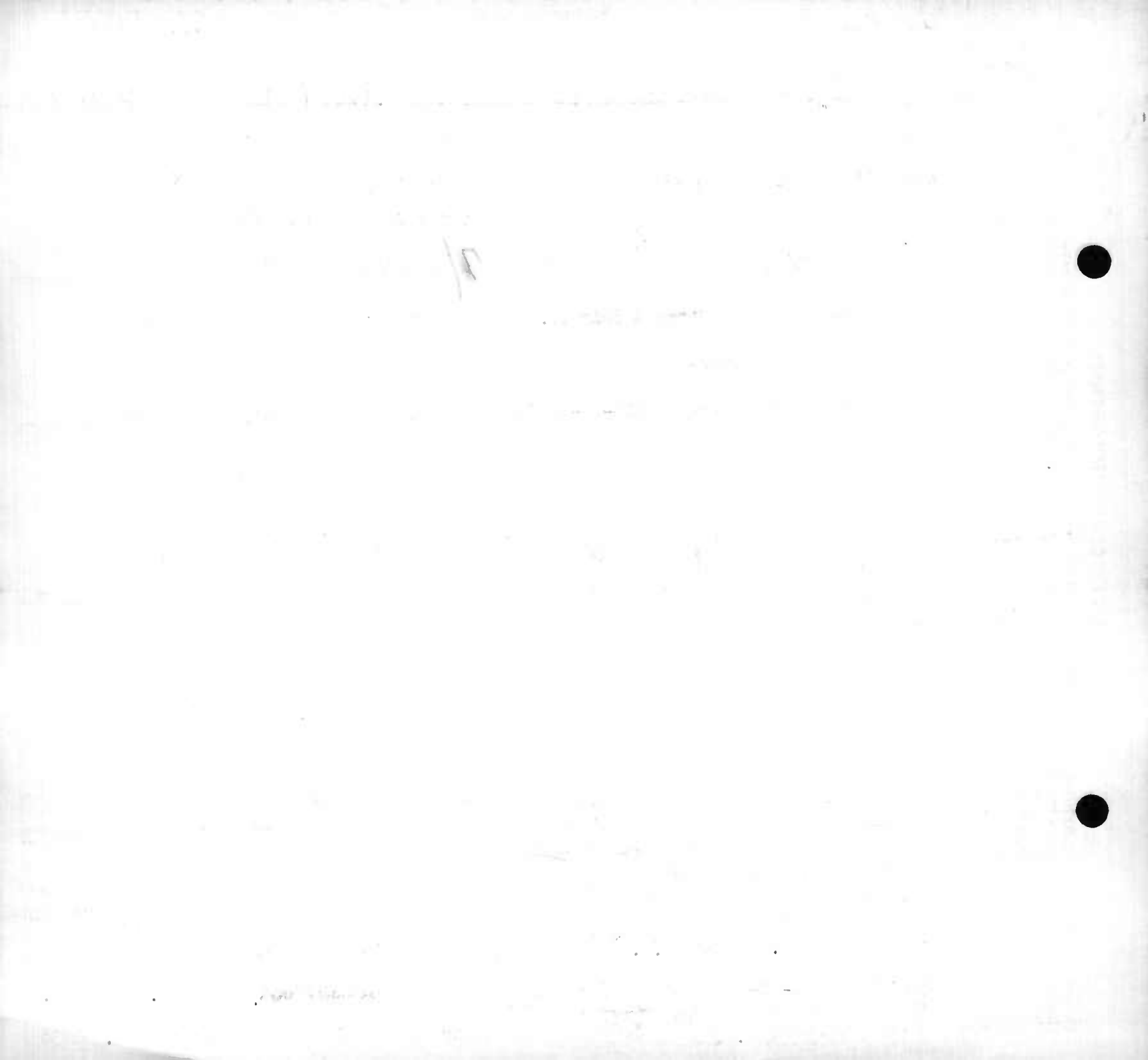
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|---|--|--|---|--|--|---|--|
| 71 0664 CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | | | | REG. NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) MRS BELL, ROSE. H | | | | | 2. DATE AND HOUR OF DEATH 1/20/1971 4.20 A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL | | | | | A. STATE MARYLAND | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | B. COUNTY 13-05 | | | | |
| | | | | | C. CITY OR TOWN BALTIMORE | | | | |
| | | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| | | | | | E. STREET AND NUMBER 828 W. 32ND STREET | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED | | 8. DATE OF BIRTH 03-22-1899 | | 9. AGE (in years last birthday) 71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine-Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Noxell Corp. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | | |
| 13. FATHER'S NAME PETE MARKEY | | | | | 14. MOTHER'S MAIDEN NAME MAY Jordan | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 216-20-6367 | | 17. INFORMANT UNION MEM. HOSP. ADMISSION HISTORY | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 191X I | | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE WIDESPREAD METASTATIC CARCINOMA (BRAIN, LIVER, BONE MARROW etc) | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) - | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | | | |
| 21D. TIME OF INJURY (APPROX.) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 11-24-1970 to 1-20-1971 that (H) (we) last saw the deceased alive on 1-19-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Rau | | | | | 23B. DATE SIGNED 1.20.1971 | | | 23C. PHYSICIAN'S NAME (Type) DR. R. RAU | |
| 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Zion United Brethren Cem., Balto, Co., Md | | 24D. LOCATION (City, town, or county) (State) Balto, Co., Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Blair E. ... | | 25C. FUNERAL DIRECTOR Donovan Funeral Home | | ADDRESS 3818 Roland Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

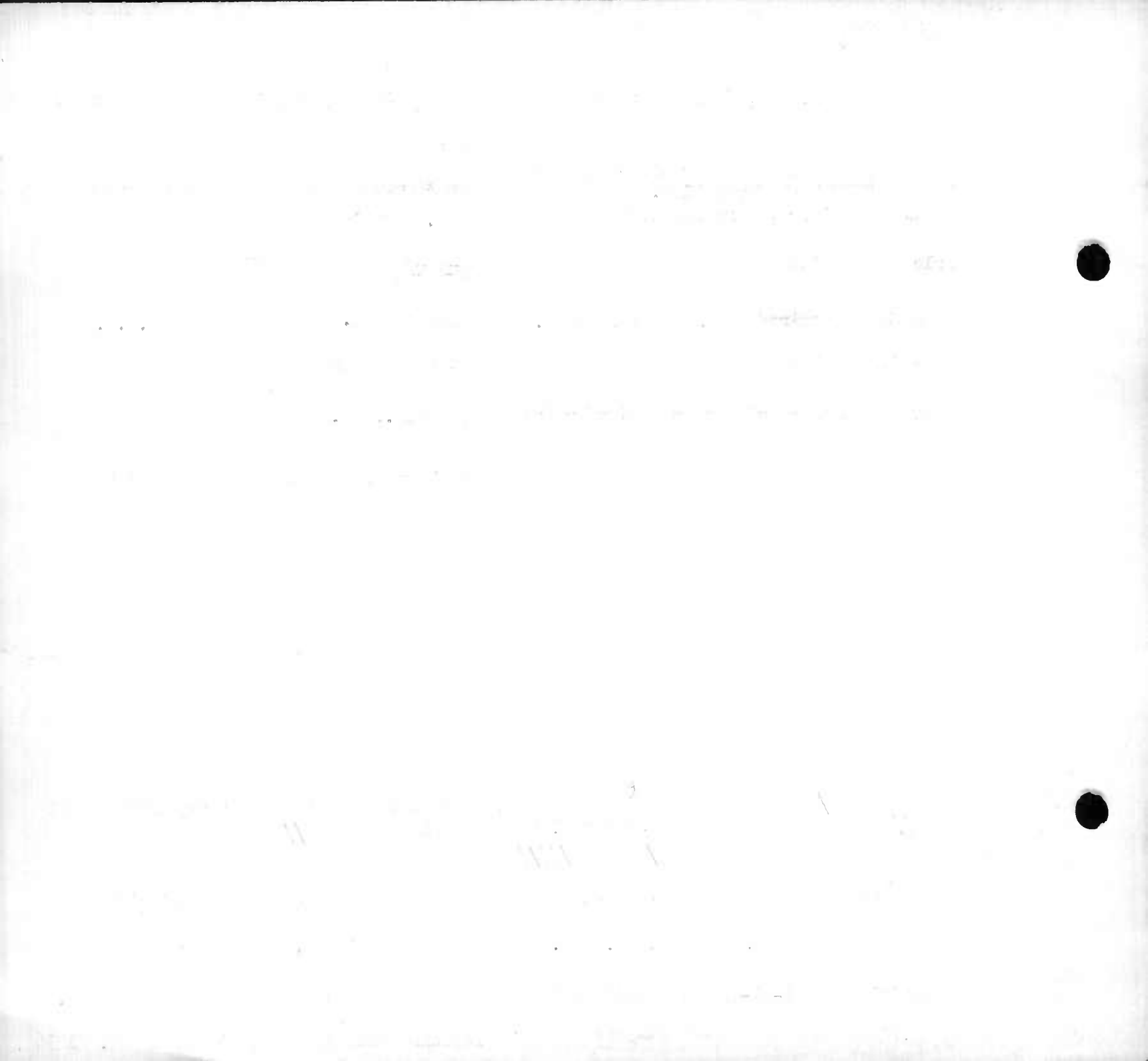
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0665</u> |
|---|---|---|--|--|
| BIRTH NO. <u>A-652</u> | | 71 0665 | | 71 0665 |
| 1. NAME OF DECEASED (Type or Print) <u>JOHN L. ARMSTRONG</u> | | 2. DATE AND HOUR OF DEATH <u>1/17/71</u> <u>8:45 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>H4</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5872 BELAIR Rd.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/25/91</u> | 9. AGE (in years last birthday) <u>79</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHAEUR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>General Ship Co.</u> | | 11. PLACE (State or foreign country) <u>ENGLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>JOHN ARMSTRONG</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>MARY MORGAN</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI English Army</u> | | |
| 16. SOCIAL SECURITY NO. <u>218-05-6648A</u> | | 17. INFORMANT <u>Mrs. J. ARMSTRONG</u> ADDRESS <u>Sauve</u> | | |
| 18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIO PULMONARY ARREST</u> <u>12 h.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>NONE</u> | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u> |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>NO</u> |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> 19 <u>71</u> to <u>1/17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>David J. Power M.D.</u> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <u>David J. Power, M.D.</u> |
| 23D. ADDRESS <u>Union Memorial Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>1-21-71</u> | 24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Pitchie Hwy. Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | 25B. NAME OF REGISTRAR <u>Blue E. [unclear]</u> | 25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u> | ADDRESS <u>7401 Belair Rd. 21236</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0666 | |
|---|---|--|---|---|--|
| BIRTH NO. M-254 | | 71 0666 | | | |
| 1. NAME OF DECEASED (Type or Print) McMULLEN, Jacob Clarence | | | 2. DATE AND HOUR OF DEATH January 18, 1971 6:30 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | | A. STATE Maryland B. COUNTY Balt Co | | |
| C. CITY OR TOWN Baltimore | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 9 S. Hawthorne Rd | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-26-97 | 9. AGE (in years last birthday) 73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Grace Machine Co. | | 11. BIRTHPLACE (State or foreign country) Johnstown Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John McMullen | | | |
| 14. MOTHER'S MAIDEN NAME Katura Kulsman | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 4-26-18-to 6-26-19 | | | |
| 16. SOCIAL SECURITY NO. 218-03-54-14 | | 17. INFORMANT Records Address VAH, Balto., Md. 21218 | | | |
| 18. CAUSE OF DEATH 185 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 16th 19 71 to January 18th 19 71 that (I) (we) last saw the deceased alive on January 18th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James A. Quinlan, Jr. MD | | | 23B. DATE SIGNED 1/18/71 | | |
| 23C. PHYSICIAN'S NAME (Type) JAMES A. QUINLAN, JR., MD. | | | 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-21-71 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION Baltimore | | 24E. CITY, TOWN, or COUNTY Md. | | 24F. STATE Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, MD | | 25C. FUNERAL DIRECTOR Lassahn Funeral Home | |
| | | | | ADDRESS 7401 Belair Rd. 21236 | |



4-620

71

0667

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

0667

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) George Calvin Horak | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 71 3:15 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 4 Dec. 1908 | | 10. AGE (In years lost birthday) 62 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician | | 14B. KIND OF BUSINESS OR INDUSTRY Lasting Paint Co. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 215-09-2940 | |
| 15. MOTHER'S MAIDEN NAME Agnes Wheeler | | 18. INFORMANT Bertha E. Horak | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 22 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) Month Day Year Hour 1 18 71 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) yes | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 1/19/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 22 Jan 71 | |
| 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. JAN 23 1971 | | 25B. NAME OF REGISTRAR James E. Gabley, M.D. | |
| 25C. FUNERAL DIRECTOR Lassahn Funeral Home | | ADDRESS 7401 Belair Rd. 21236 | |

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EXHIBIT 1

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BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM G. DAVIS

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
Jan. 20, 1971 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 114 S. Ann St.

3. DATE PRONOUNCED DEAD Month Day Year Hour
1 20 1971 5:10 a M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY 2-02

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

June 15, 1901

10. AGE (In years
last birthday)

69

Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

114 S. Ann St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

William Davis

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Etta M. Curry

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

217-09-0643

18. INFORMANT

ADDRESS

William P. Davis Mechanicsville, Maryland

19. 185 X 1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Carcinoma of prostate
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan. 23, 1971

24C. NAME of CEMETERY or CREMATORY

Mt. Zion Cemetery

24D. LOCATION (City, town, or county) (State)

Laurel Grove, St. Mary's, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

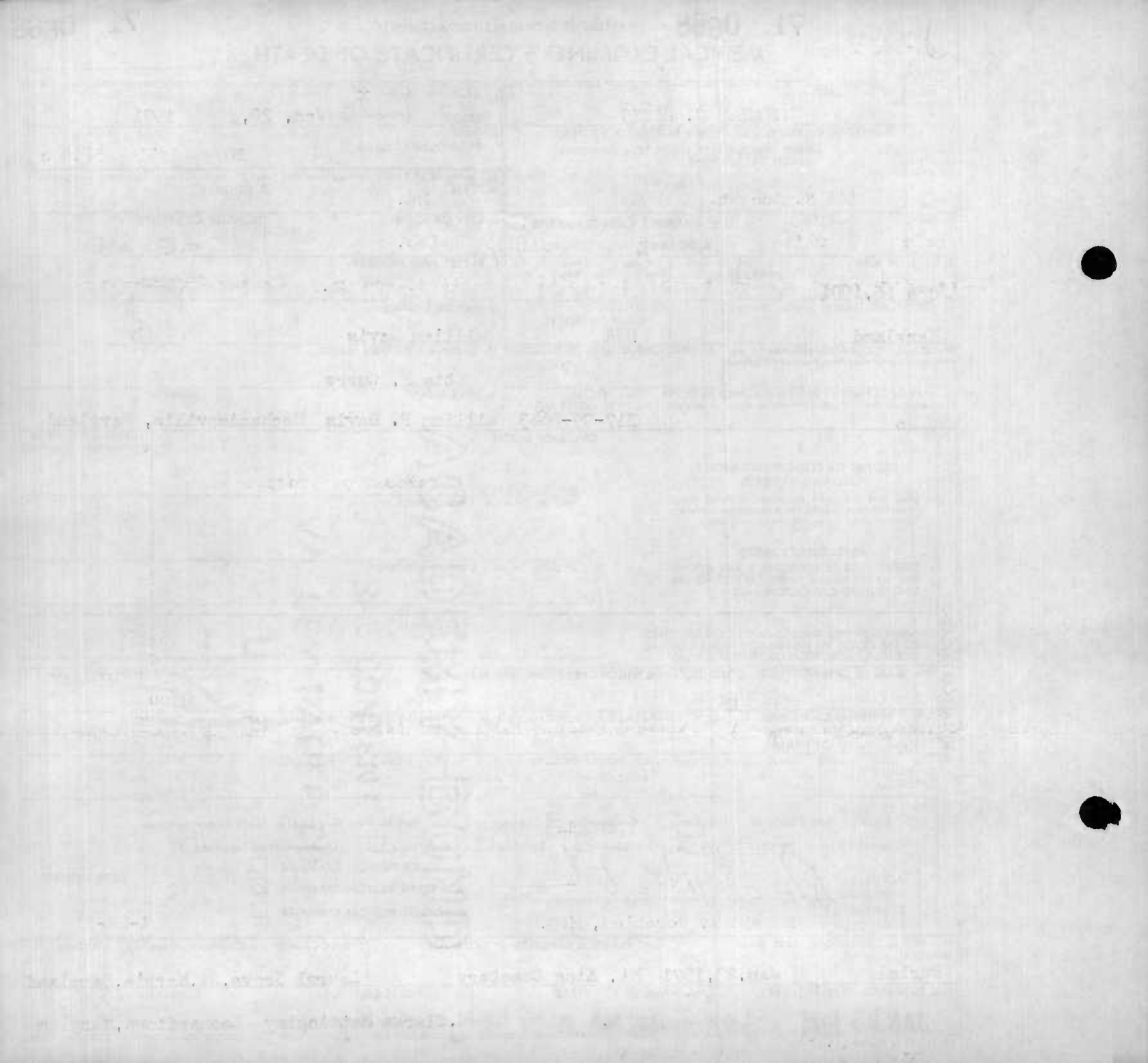
25C. FUNERAL DIRECTOR

ADDRESS

JAN 25 1971

Robert E. Taylor, Jr.

W. Clarke Mattingley Leonardtown, Maryland



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. No. 71 0669 | |
| G-000 71 0669 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Guy, Joan E. | | 2. DATE AND HOUR OF DEATH Jan 19, 1971 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY A. A. | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33 | | C. CITY OR TOWN ANNAPOLIS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 6 THORN CT. | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 08-29-39 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY own home | 9. AGE (In years last birthday) 31 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) Johnstown, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME THOMAS LESLEY MILLER | | 14. MOTHER'S MAIDEN NAME DOROTHY MILLER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 199-30-3854 | |
| 17. INFORMANT John W. Guy | | ADDRESS husband same as E | |
| 18. 172.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Malignant Melanoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION 22 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 4 19 71 to Jan 19 19 71 , that (I) (we) last saw the deceased alive on Jan 19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Stephen T. Miller MD | | 23B. DATE SIGNED Jan 19, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Stephen T. Miller, M.D. | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Jan 22 1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Hillcrest Cemetery | | 24D. LOCATION (City, town, or county) (State) Annapolis, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert J. Beall | |
| 25C. FUNERAL DIRECTOR Beall Funeral Home | | ADDRESS 1212 West St Anna., Md. | |

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FUNERAL DIRECTOR: IMPORTANT

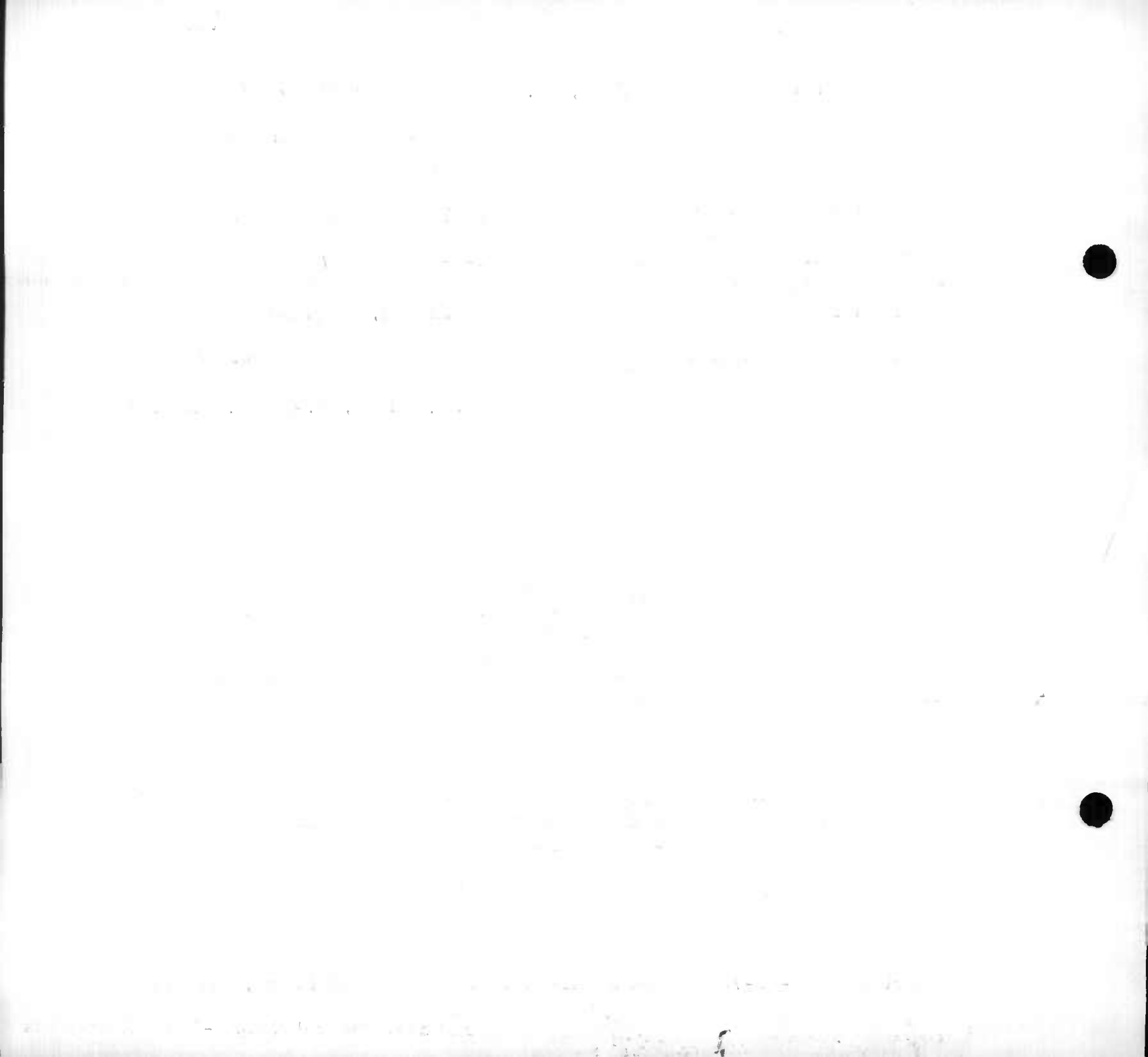
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|---|--|--|---|---------------------------------|--|
| S-512 71 0670 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0670 | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Simpson, Charles</u> | | | | | 1/14/71 12 mn M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>St Marys 68-00</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital, Balt., md</u> | | | | | C. CITY OR TOWN <u>CALIFORNIA</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | E. STREET AND NUMBER <u>Bx 338</u> | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>? DIVORCED</u> <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/22/04</u> | 9. AGE (In years last birthday) <u>66</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNK.</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>UNK.</u> | | 11. BIRTHPLACE (State or foreign country) <u>UNK.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Charles Simpson</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>GRAIN</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>256260960</u> | | 17. INFORMANT <u>HOSPITAL RECORDS</u> | | ADDRESS | | |
| 18. <u>412.4 I</u> CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Edema</u> | | | | | <u>4 hrs</u> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> | | | | | <u>10-20 yrs.</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>pneumonia</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> XXXXXXXXXX | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JAN 14 8pm 71</u> to <u>JAN 14 12mn 71</u> , that (I) (we) last saw the deceased alive on <u>JAN 14 12mn 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Donald L. Trump</u> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1/15/71</u> <u>IAN</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>DONALD TRUMP</u> | | | | | 23D. ADDRESS <u>601 N. BROADWAY BALT, MD</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-20-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>1st BAPTIST CEMETERY</u> | | 24D. LOCATION <u>LEXINGTON PARK, MD</u> | | (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. J. J. J.</u> | | 25C. FUNERAL DIRECTOR <u>JOHN M. WELCH</u> | | ADDRESS <u>LEONARDTOWN, MD</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

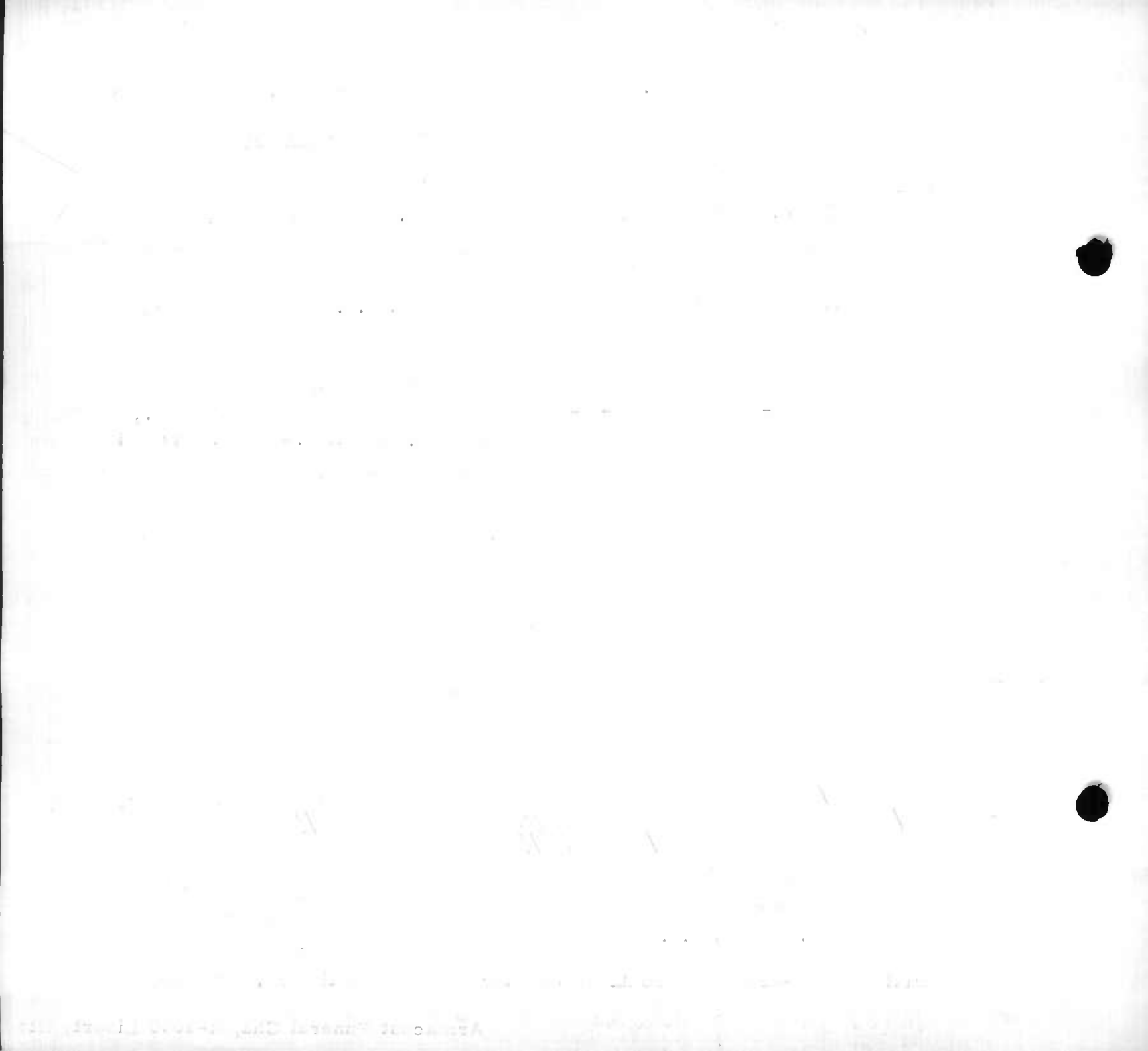
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| K-260 71 0671 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0671 | |
|---|--|---|--|---|----------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | William H Kaiser, Sr. | | January 20, 1971 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland | | Baltimore | |
| 5807 Gwynn Oak Avenue | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 5807 Gwynn Oak Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. Months Days |
| Male | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 6-2-1892 | 78 | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Machinist | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Henry Kaiser | | Yentner | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | Wm. H. Kaiser, Jr. - 503 S. 46th St 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | | Disease | |
| DUE TO, OR AS A CONSEQUENCE OF: | | Ante Myocardial Infarction | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Generalized arteriosclerosis, Esophageal ulcer, Atrial fibrillation | | 4 years. | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 1969 to Present/Jan 1971 that (I) (we) last saw the deceased alive on 1/19/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Herman Brecher, M.D. | | 1/21/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Herman Brecher, M.D. | | 6410 Windsor Mill Rd Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 1-23-71 | Loudon Park Cemetery | Baltimore, Maryland | | |
| 25A. DATE RECD BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 25 1971 | Robert E. Taylor, R.D. | Armocost Funeral Chapel | | 4600 Liberty Hts | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

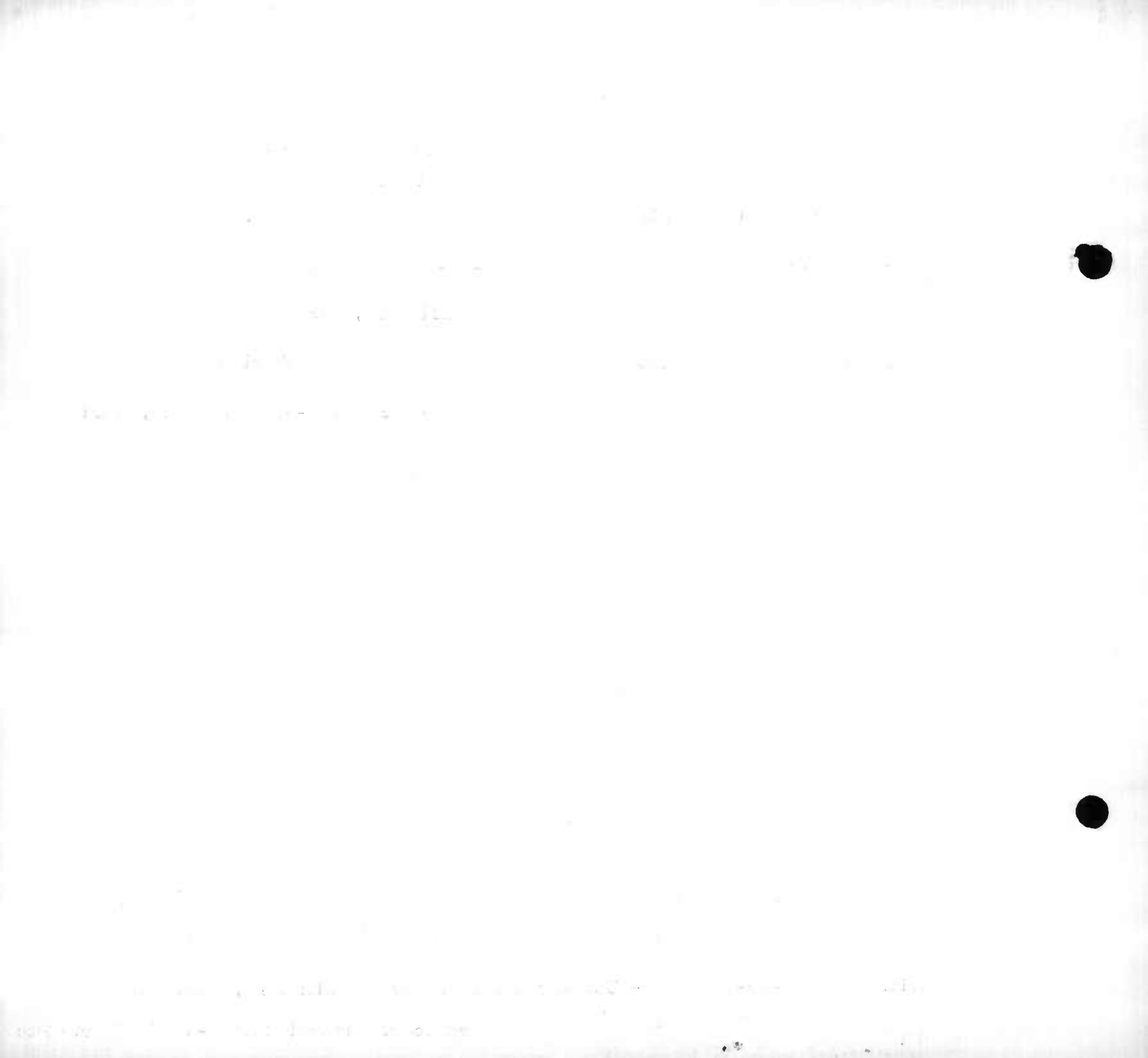
| | | | | | |
|---|---------|---|------------------|---|---|
| 71 0672 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0672 | |
| J-630 | | CERTIFICATE OF DEATH | | REG. NO. | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | JARRETT, JAMES L Sr. | | January 19, 1971 10:50 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland Baltimore 12-02 | | | |
| 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 352 E. University Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| Male | White | | 4/21/16 | 54 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Attendant | | Used car lot | | Marshall, N.C. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| USA | | George Jarrett | | Flora Rector | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes 9/22/42-5/25/44 | | 242-09-4655 | | VA Hospital Records 3900 Loch Raven Boulevard, Balto., Md 21218 | |
| 18. CAUSE OF DEATH | | James L. Jarrett Jr. - 352 E. University Avenue | | APPROXIMATE INTERVAL BETWEEN DEATH AND EXAMINATION | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 2 to 3 hours | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF: | | minutes | |
| ANTECEDENT CAUSES | | (C) Metral insufficiency DUE TO, OR AS A CONSEQUENCE OF: | | years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II Bronchopneumonia | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | Yes | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 7th 1970 to January 19th 1971 that (I) (we) last saw the deceased alive on January 19th 1971 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| John F. Rogers | | 1/20/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JOHN F. ROGERS, M.D. | | 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1-23-71 | | Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Baltimore, Maryland | | JAN 25 1971 | | E. J. Taylor, M.D. | |
| 24G. FUNERAL DIRECTOR | | 24H. ADDRESS | | | |
| Armocost Funeral Chapel-4600 Liberty Hts | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0673</u> | |
|---|--|---|--|--|--|
| 11-623 71 0673 | | BIRTH NO. | | 2. DATE AND HOUR OF DEATH <u>11/19/71</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Louis Marsden</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Union Memorial Hospital</u> | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | 5. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 6. STREET AND NUMBER <u>5511 Belle Ave.</u> | | 7. SEX <u>Male</u> 8. RACE <u>White</u> 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>1-24-1881</u> 9. AGE (in years last birthday) <u>89</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>James H Marsden</u> | | 14. MOTHER'S MAIDEN NAME <u>O'Brien</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Rodney McSwiney-Jensen Beach, Florida</u> | |
| 18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u> <u>A.T.S.</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension</u> (C) <u>A.T.S.</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years -</u> <u>"</u> <u>"</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> 19 <u>70</u> to <u>11/19</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>11/19</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>S. TANENDAW</u> | | 23B. DATE SIGNED <u>11/21/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>S. TANENDAW</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-23-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>Blair E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR <u>Armatost Funeral Chapel</u> | | 25D. ADDRESS <u>-4600 Liberty Hts</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

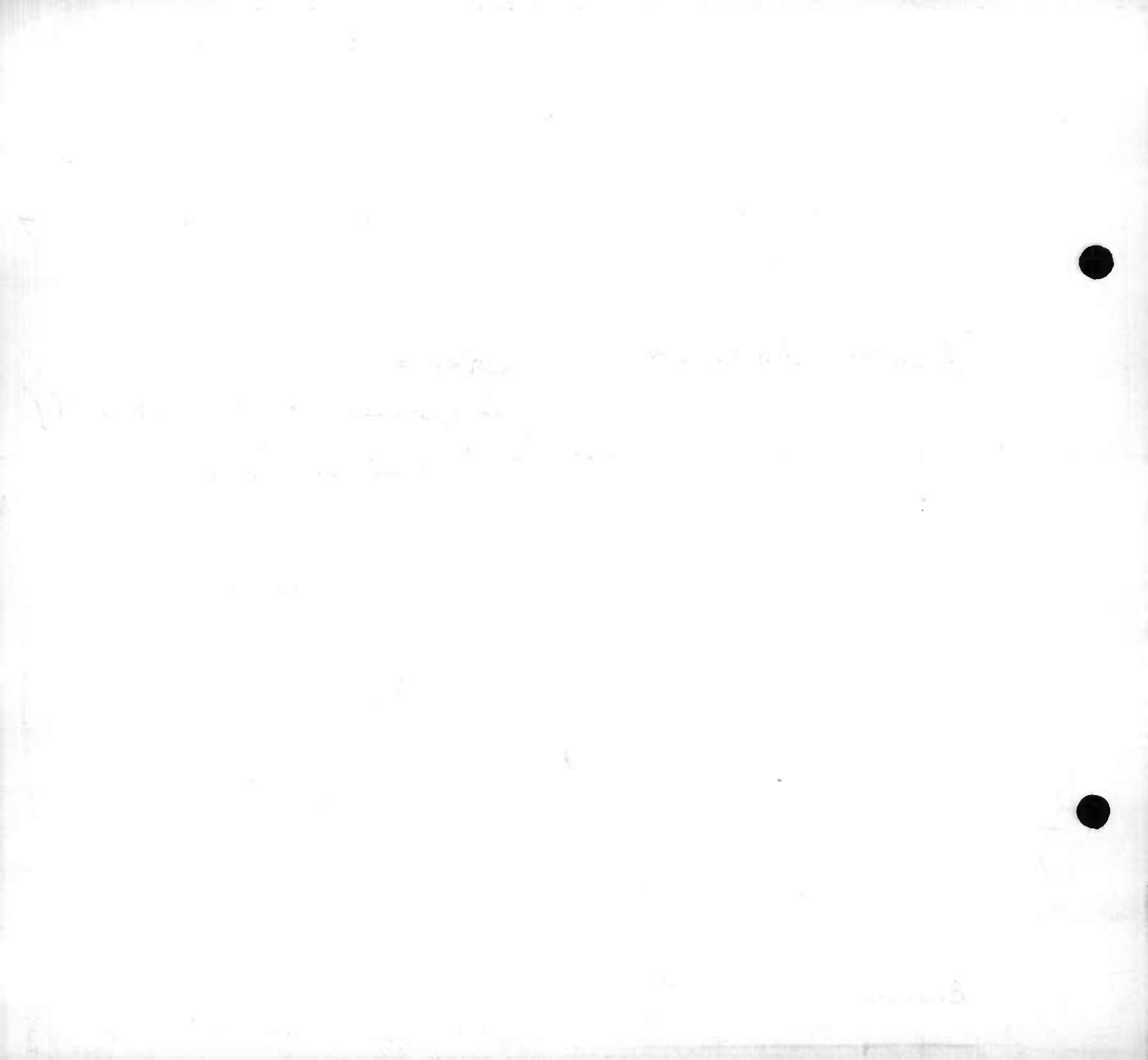
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------|--|------------------|--|-----------------------------|
| B-650 71 0675 | | 71 0675 | | 71 0675 | |
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| James Brown | | 1-20-71 | | 112 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| Full Name of Hospital or Institution (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| HARBORVIEW ENV. CENTER | | MD | | 22-01 | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 843 Lindenhall St. Leadenhall | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Male | Negro | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 4-5-19 | 51 | 11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Truck Driver | | Transfer Co. | | Baltimore MD | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| James Brown | | Mary Lou Murray | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| yes | | 215-07-0181 | | Hilda B. Singleton 3019 Southland Ave | |
| 18. 161.9 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Tea of Lung | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Lung cancer | | | |
| | | (C) Gastroscopy | | | |
| | | 3 wk | | | |
| | | 3 wk | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/9 1971 to 1/20 1971 that (I) (we) last saw the deceased alive on 1/9 1971 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| JOS. S. BLUM MD | | 1/22/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JOS. S. BLUM MD | | 1115 N Calvert St | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1/25/71 | | Baker National | |
| | | | | Baltimore MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 25 1971 | | R. E. Taylor, M.D. | | M. H. Taylor, 6388 Glenview St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

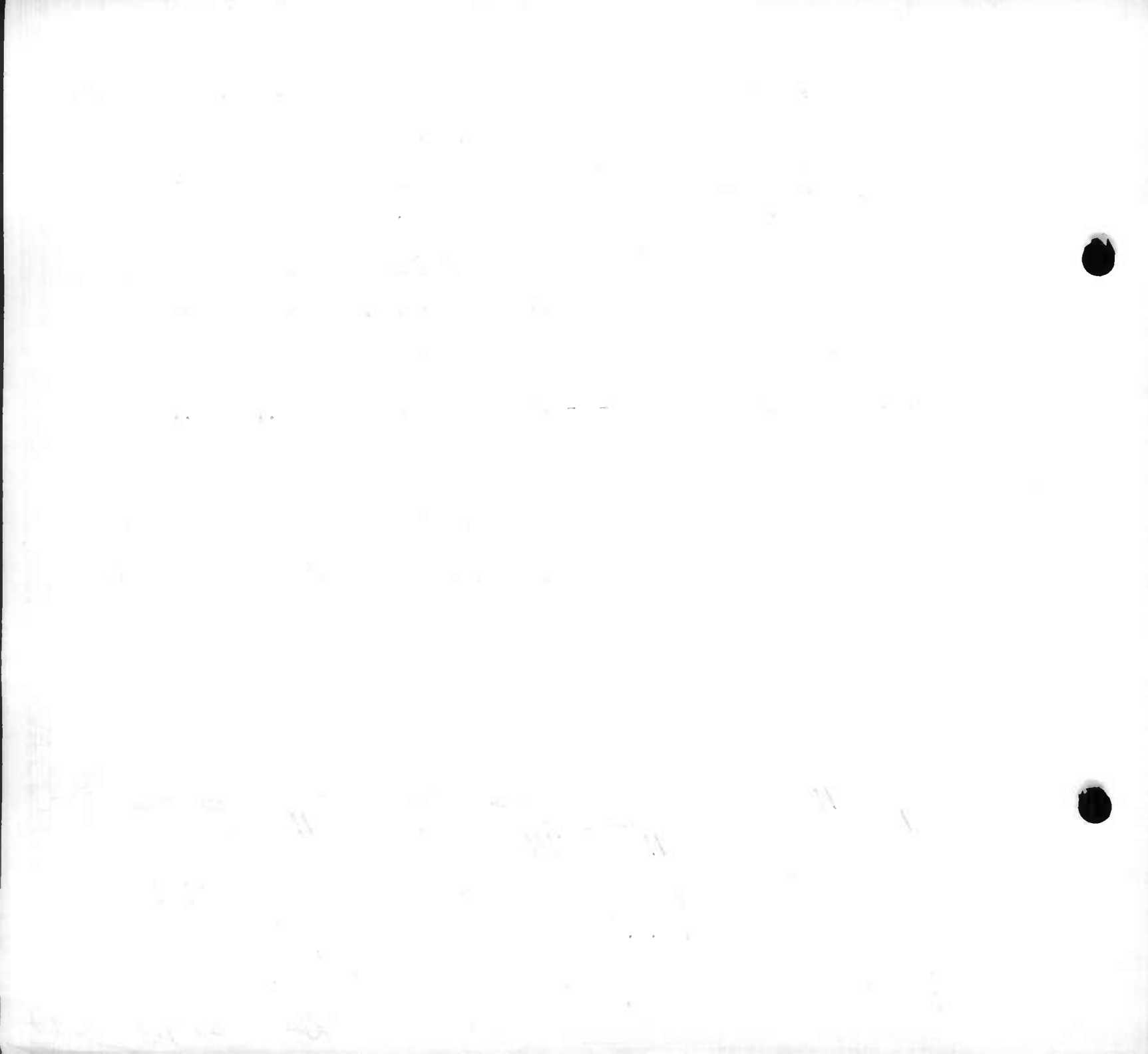
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0676</u> | |
|--|---------------------|--|------------------------------------|--|---|
| E-524 <u>71 0676</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>HARRY ENGLISH</u> | | 2. DATE AND HOUR OF DEATH <u>JAN. 18, 1971 8:05 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>18 MD. GEN. HOSP.</u> <u>827 LINDEN AVE.</u> | | A. STATE <u>MD.</u> | | B. COUNTY <u>BALTO.</u> | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>4105 WOODRIDGE RD 21229</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-20-08</u> | 9. AGE (In years last birthday) <u>62</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Soc. Security</u> | | 11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>DONALD ENGLISH</u> | | 14. MOTHER'S MAIDEN NAME <u>KATIE</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT <u>Harry English 4105 Woodridge Rd</u> | |
| 18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ISCHEMIC HEART DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CARDIAL ARREST</u> <u>CARDIOVASCULAR</u> | | CAUSE OF DEATH <u>ISCHEMIC HEART DISEASE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAL ARREST</u> (B) <u>CARDIOVASCULAR</u> (C) <u>CARDIOVASCULAR</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>925</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> 19 <u>71</u> to <u>1/18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Leo A. Courtney, M.D.</u> | | 23B. DATE SIGNED <u>1/18/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>LEO A. COURTNEY, M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1/25/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Cornwall Manor P.R.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> | | 24E. NAME OF REGISTRAR <u>Robert E. Valley, R.A.</u> | | 24F. FUNERAL DIRECTOR <u>Donna G. Kellum</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Valley, R.A.</u> | | 25C. FUNERAL DIRECTOR <u>Donna G. Kellum</u> | |
| 25D. ADDRESS <u>135 N. GILMAN ST.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 71 0677 | |
|--|----------------------|---|----------------------------------|--|---|
| BIRTH NO. 18-260 | | 71 0677 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BOOKER, Enory | | 2. DATE AND HOUR OF DEATH January 19, 1971 10:20 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | A. STATE Maryland B. COUNTY 6-03 | | | |
| C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 416 N. Patterson Park Avenue | | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/11/11 | 9. AGE (in years last birthday) 59 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10B. KIND OF BUSINESS OR INDUSTRY National Detective | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Samuel Booker | | 14. MOTHER'S MAIDEN NAME Thomas | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES NO None | | 16. SOCIAL SECURITY NO. 213-03-8879 | | 17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md | |
| 18. 404 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS YEARS | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that my (this hospital) attended the deceased from January 3rd 19 71 to January 19th 19 71 that we lost saw the deceased alive on January 19th 19 71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. my (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kameel Farag | | 23B. DATE SIGNED 1/20/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) KAMEEL FARAG, M.D. | | 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | | 24C. NAME OF CEMETERY OR CREMATORY West Annapolis | |
| 24D. LOCATION (City, town, or county) Baltimore | | (State) Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Franklin P. Hays | |
| 25D. ADDRESS 657 N. Gilem St | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|------------------|---|---|--|---|--|---------------------------------------|
| F-300 | | 71 0678 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0678 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) ROUT, CHARLES R. | | | | 2. DATE AND HOUR OF DEATH 1 21 71 3:55PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO CO | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL WILKENS & CATON AVES.-BALTO., MD. | | | | C. CITY OR TOWN BALTO. 21228 | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX | |
| E. STREET AND NUMBER 400 FREDERICK RD. | | | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8 24 92 | 9. AGE (In years last birthday) 78 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED/ENGINEER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND, USA | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME JAMES ROUT | | | 14. MOTHER'S MAIDEN NAME (BLOOM) SAVILLE | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BALTO., MD. ST AGNES HOSP., WILKENS & CATON AVES. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A S C V D Cardiac arrhythmia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unk | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Anemia | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (he) (this hospital) attended the deceased from 1 21 71 to 1 21 71 that (we) last saw the deceased alive on 1 21 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE JOSE APTER, M.D. | | | | 23B. DATE SIGNED 1/22/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) JOSE APTER, M.D. | | | | 23D. ADDRESS ST AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/25/71 | | 24C. NAME OF CEMETERY OR CREMATORY MT. OLIVET | | 24D. LOCATION (City, town, or county) (State) FREDERICK MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR R. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR E. S. MacNabb | | 25D. ADDRESS 301 Frederick Rd | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

0680

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) PAUL HERMAN WISSING | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year January 20, 1971 Hour 4:55 P. M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 16 JULY 07 | | 10. AGE (In years lost birthday) 63 | |
| 11. BIRTHPLACE (State or foreign country) W. VA. | | 12. CITIZEN OF U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 14B. KIND OF BUSINESS OR INDUSTRY POST OFFICE | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. | |
| 15. MOTHER'S MAIDEN NAME MARGARET PAUL | | 18. INFORMANT Mrs. Marie Wissing, 4374 Shamrock Ave. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) Yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 23 JAN 71 | |
| 24C. NAME OF CEMETERY or CREMATORY OAK LAND CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTO. CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR CLERIGH FUNERAL HOMES, BALTO. MD. | | ADDRESS 21206 | |

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U.S.A.

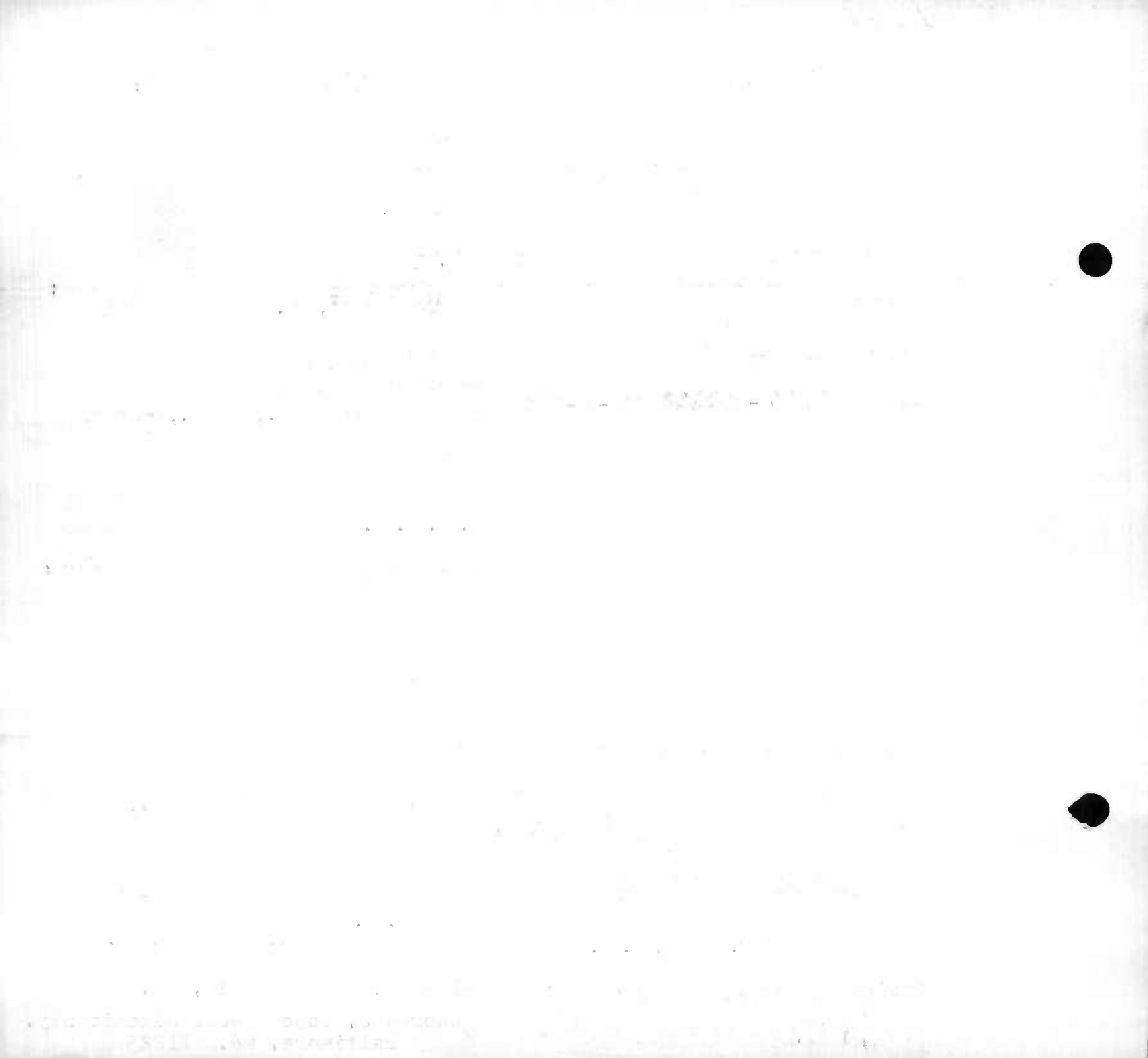
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0681 | |
|--|-----------------------------|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> H-634 71 0681 </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) HARTLESS, Robert Roy | | 2. DATE AND HOUR OF DEATH 1/21/71 1:45 A | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard | | | A. STATE Maryland B. COUNTY A. A. Co. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 700 "O" Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9/2/21 | 9. AGE (In years last birthday) 49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Burena Vista, Va. | |
| 13. FATHER'S NAME William Hartless | | | 14. MOTHER'S MAIDEN NAME Ollie Nuckles | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes 9/27/43 - 2/26/48 | | 16. SOCIAL SECURITY NO. 229-12-2652 | | 17. INFORMANT ADDRESS VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 2128 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C. O. P. D. Pericarditis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Week Several Years Several Months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 13, 1971 to January 21, 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 21, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Kameel F. Farag</i> | | | | 23B. DATE SIGNED 1-21-71 | |
| 23C. PHYSICIAN'S NAME (Type) Kameel F. Farag, M. D. | | | | 23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/23/71 | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk. | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR George J. Gonce | | 25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0682

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Ida M. Lehman | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 19 71 12:15p M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 116 W. Lee St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 19 71 12:15p M. | |
| 6. SEX female | | 7. RACE white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH June 13, 1912 58 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (in years last birthday) 58 | | E. STREET AND NUMBER 116 W. Lee St. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Gilbert L. Maris | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Emma Brown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 220 12 4642 | | 18. INFORMANT Ernest Lehman Severna Park, Md. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. DATE SIGNED: 1/19/71 EXAMINER'S NAME (Type): Werner U. Spitz, M.D. Deputy Chief Medical Examiner | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/23/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR George J. Gonce | |
| 25C. FUNERAL DIRECTOR George J. Gonce | | ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225 | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0683

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH KLUNK, Jr.

2. DATE
OF
DEATHKnown ☒

Month

Day

Year

Hour

Estimated ☐

January

21,

1971

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January 21, 1971

7:30 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

12-02

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

June 15, 1925

10. AGE (In years
lost birthday)

45

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

409 E. 31st Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Lee Klunk, Sr.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY

Steel Industry

15. MOTHER'S MAIDEN NAME

Louise M. Anders

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

17. SOCIAL
SECURITY NO.

219-18-5282

18. INFORMANT

Louise A. Klunk

ADDRESS

409 E. 31st St.
Baltimore, Md.

19.

E 880X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Massive, acute pulmonary thromboembolism

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Fracture of left lower extremity

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Stairs

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

409 E. 31st St. Fell down stairs

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

1-1-71

?

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Fell because of snow on stairs

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 21, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan. 23, 1971

24C. NAME OF CEMETERY or CREMATORY

Evergreen Memorial Car. Finksburg, Maryland

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Owings Mills, Md.

8890

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71 0684

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0684

BIRTH NO.

REG. NO.

| | | | | | | | |
|---|--|--|--|---|-----|---|-----------|
| 1. NAME OF DECEASED (Type or Print) VANDER LEE DAVID | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secour Hospital | | 3. DATE PRONOUNCED DEAD | | Month | Day | Year | Hour |
| | | | | 1 | 21 | 1971 | 12:20p M. |
| 6. SEX male | | 7. RACE negro | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 12-10-1910 | | 10. AGE (In years last birthday) 60 | | If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER 23 N. Gilmore St. | |
| 11. BIRTHPLACE (State or foreign country) Sumter, S.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George W. David | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | | 14B. KIND OF BUSINESS OR INDUSTRY ***** | | 15. MOTHER'S MAIDEN NAME Christine | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 217-07-6392 | | 18. INFORMANT Geneva David | | ADDRESS 876 Sterling Place Brooklyn, New York | |
| 19. CAUSE OF DEATH 571.81 | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Isidore Mihalakis</i> M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-22-71 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-27-71 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR Vernon R. Bailey | | ADDRESS Kelson Funeral Home 1348 N. Calhoun | |

1830 IV

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FUNERAL DIRECTOR: IMPORTANT

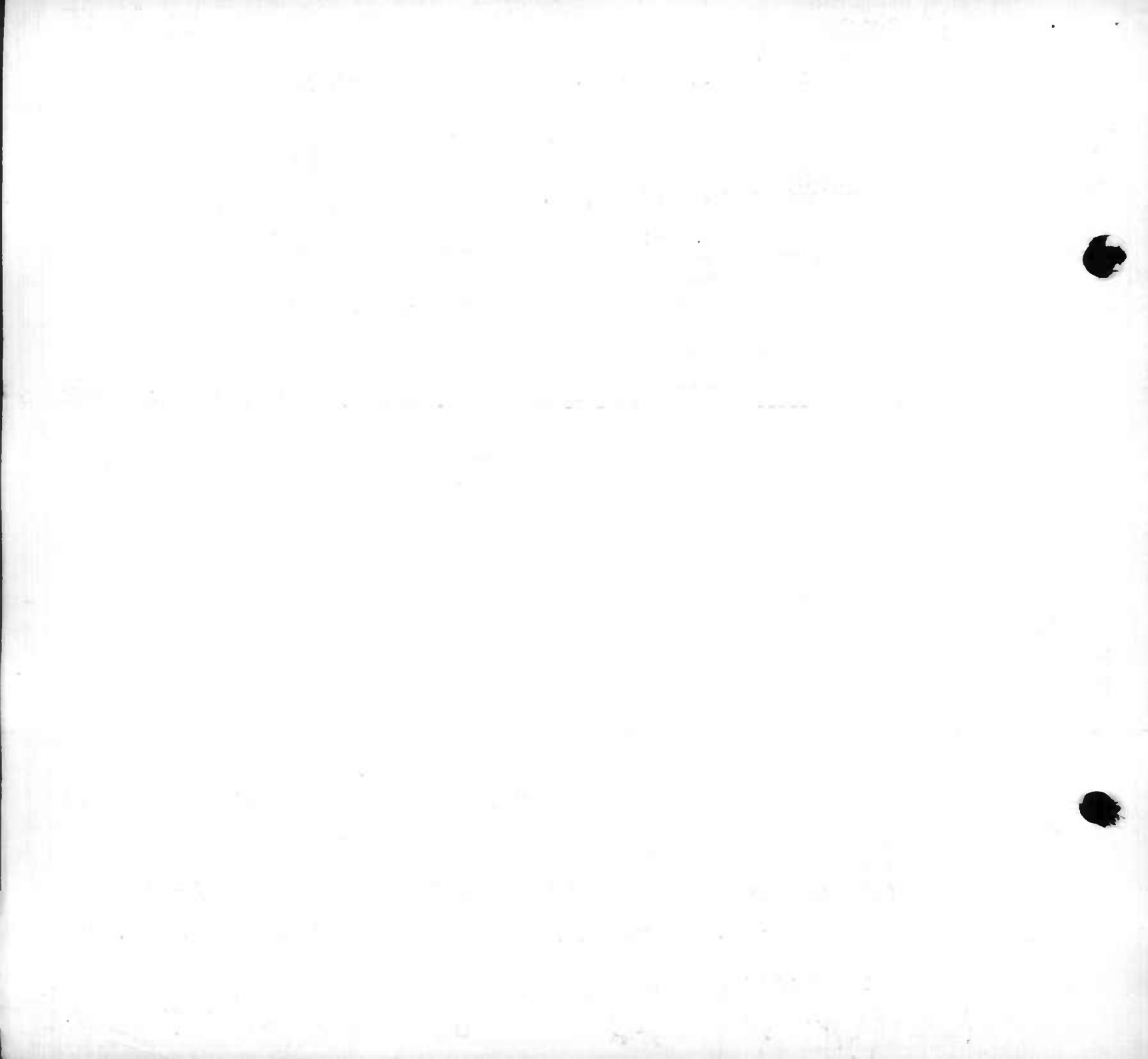
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0685 | |
|---|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> B-620 71 0685 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) SADIE BRICE | | 2. DATE AND HOUR OF DEATH 11/22/71 6²⁰ A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hosp. | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Wynsboro, S.C. | |
| 13. FATHER'S NAME Charles Williamson | | 14. MOTHER'S MAIDEN NAME Nack Mattigan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-01-920732 | | 17. INFORMANT Bessie Roles | |
| 18. 441.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Ruptured Aortic Aneurysm | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anteriosclerotic Cardiovascular Disease Unknown | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) _____ (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) this hospital attended the deceased from 11/8 19 71 , that (I) (we) last saw the deceased alive on 11/22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert A. Vigersky, M.D. | | | | 23B. DATE SIGNED 11/22/71 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT A. VIGERSKY, M.D. | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Arbutus, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Olson | | 25C. FUNERAL DIRECTOR Vernon S. Bailey | |
| 25D. ADDRESS 1348 N. Calhoun | | 25E. ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

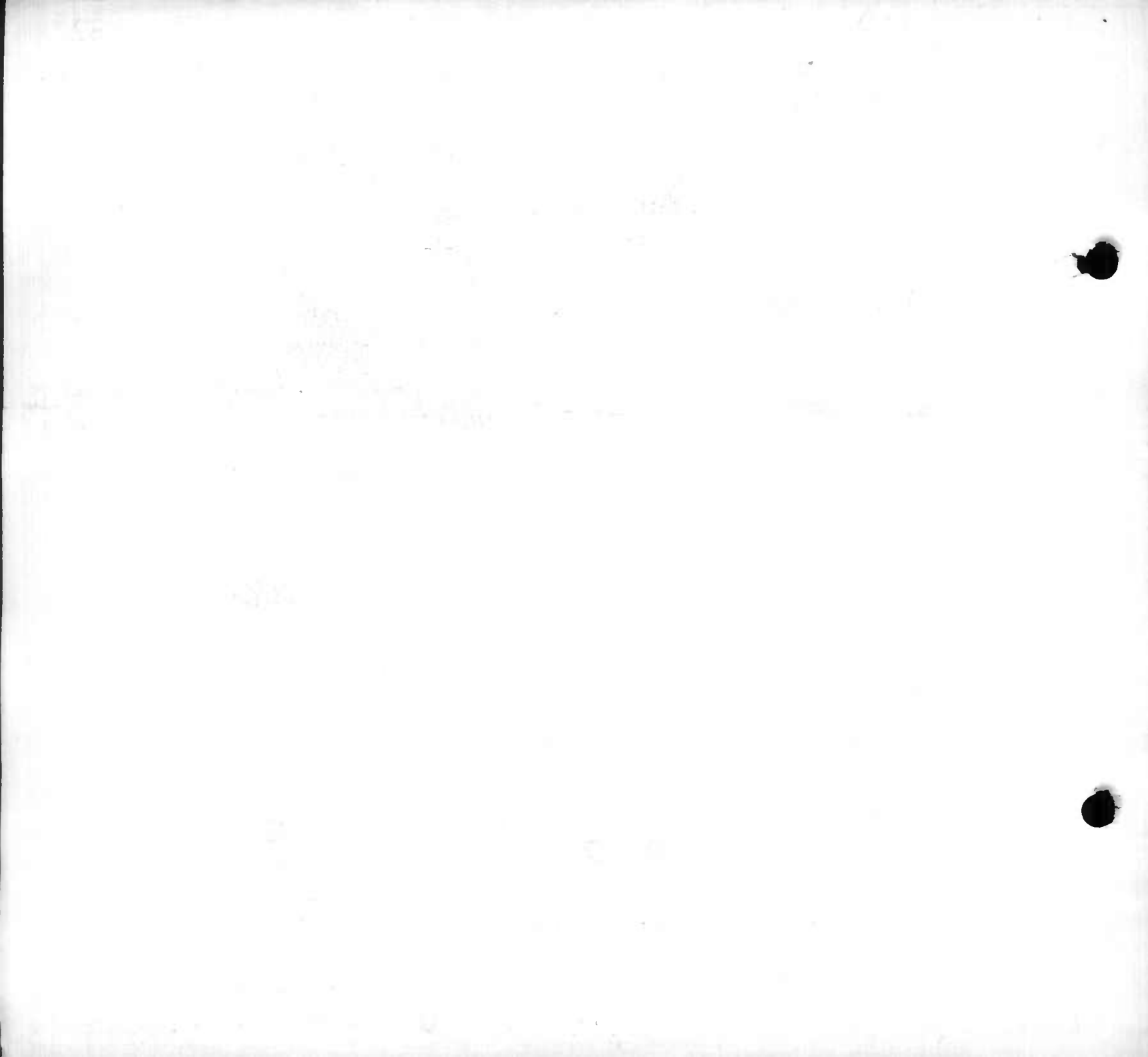
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0686 | |
|--|--|---|--|---|--|
| BIRTH NO. R-352 | | 71 0686 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Carroll M. Redding Sr. | | | 2. DATE AND HOUR OF DEATH 1/19/71 5:15 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4500 Groveland Avenue, Baltimore, Md. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 28-41 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4500 Groveland Avenue, 21215 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/4/01 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: _____ Days: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer | | | 10B. KIND OF BUSINESS OR INDUSTRY Printing | | |
| 11. BIRTHPLACE (State or foreign country) Manchester, Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 13. FATHER'S NAME William Redding | | | 14. MOTHER'S MAIDEN NAME Ada Green | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-07-3599 | | |
| 17. INFORMANT Mrs. Grace S. Redding, 4500 Groveland Avenue | | | ADDRESS 21215 | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ </div> <div style="width: 45%; text-align: right;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden. </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 66 19 to May 19 70 that (I) (we) last saw the deceased alive on 5/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) view the body after death. | | | | | |
| 23A. SIGNATURE Lawrence F. Solomon | | | | 23B. DATE SIGNED 1-19-71 | |
| 23C. PHYSICIAN'S NAME (Type) Lawrence F. Solomon M.D. | | | | 23D. ADDRESS 3600 Lochearn Drive, Baltimore, Md. 21207 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71 | | 24C. NAME of CEMETERY or CREMATORY Norland Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Chambersburg, Penna. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | | |
| 25B. NAME OF REGISTRAR 000 | | 25C. FUNERAL DIRECTOR 000 | | 25D. ADDRESS 21133 Liberty Rd. Randallstown, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

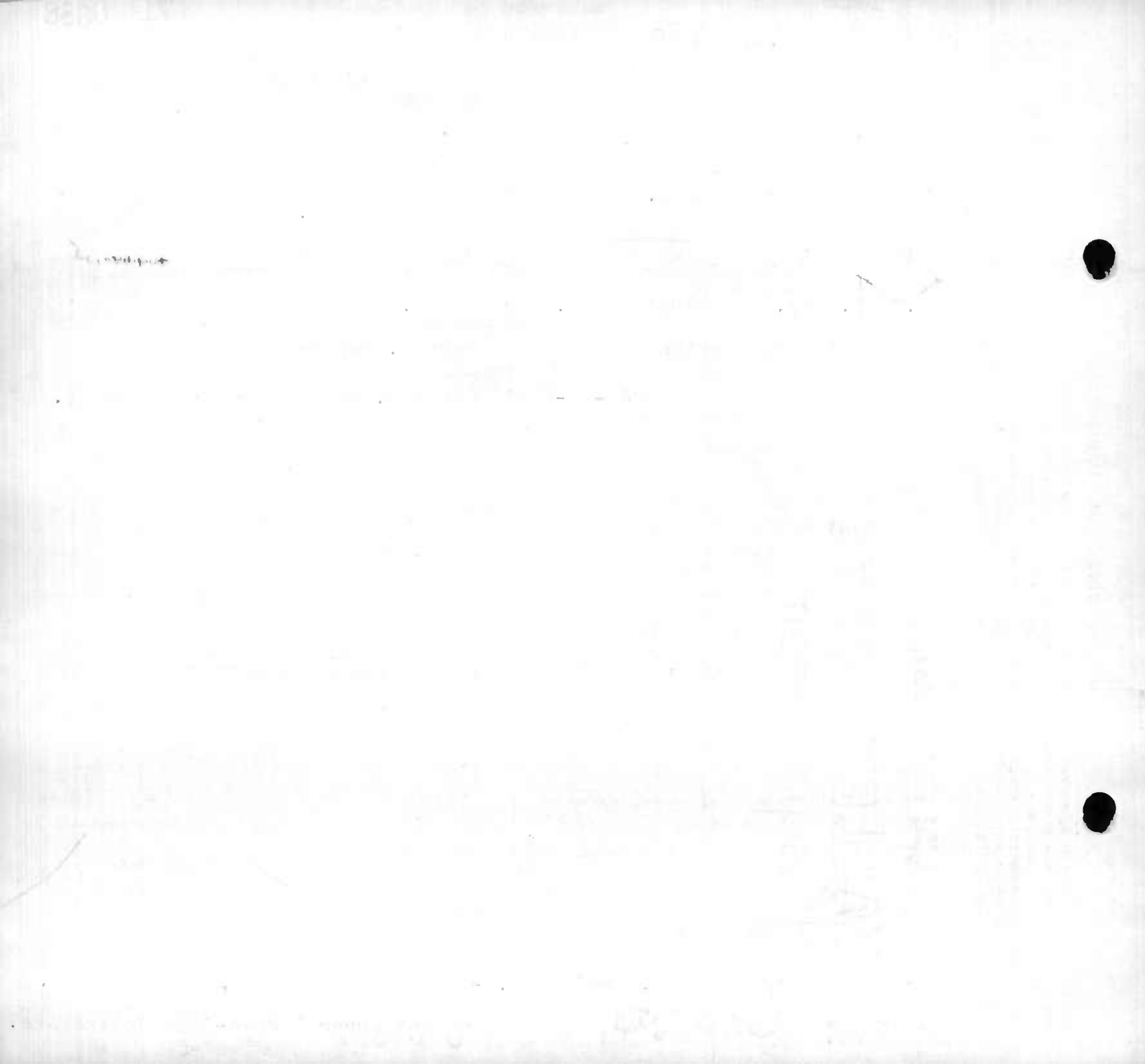
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0687 | |
|--|--|---|--|---|---|
| K-100 71 0687 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Roop, Norman H. | | 2. DATE AND HOUR OF DEATH 1/21/71 6:10 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | A. STATE Maryland B. COUNTY Baltimore | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital, Baltimore, Md. | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 5500 Huntley Square, 21210 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-4-89 | 9. AGE (in years lost birthday) 81 81 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician | | 10B. KIND OF BUSINESS OR INDUSTRY Totalisator Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John Thomas Roop | | 14. MOTHER'S MAIDEN NAME Ida Catherine Lescafeet | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES <input type="checkbox"/> World War I | | 16. SOCIAL SECURITY NO. 062-03-8410 | | 17. INFORMANT Marshall C. Roop ADDRESS 5500 Huntley Square, 21210 | |
| 18. 1519 X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Obstructive Jaundice | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) Resistant to Alcohol | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 7 19 71 to Jan 21 19 71 that (I) (we) last saw the deceased alive on Jan 21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (It) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Eugene Page, Jr. | | | | 23B. DATE SIGNED 1/21/71 | |
| 23C. PHYSICIAN'S NAME (Type) E. Eugene Page, Jr. | | 23D. ADDRESS Union Memorial Hospital, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/23/71 | | 24C. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Westminster, Carroll, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Lori U. Berr | | 25C. FUNERAL DIRECTOR ADDRESS 23 Liberty Rd. Randallstown, Md. 21133 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

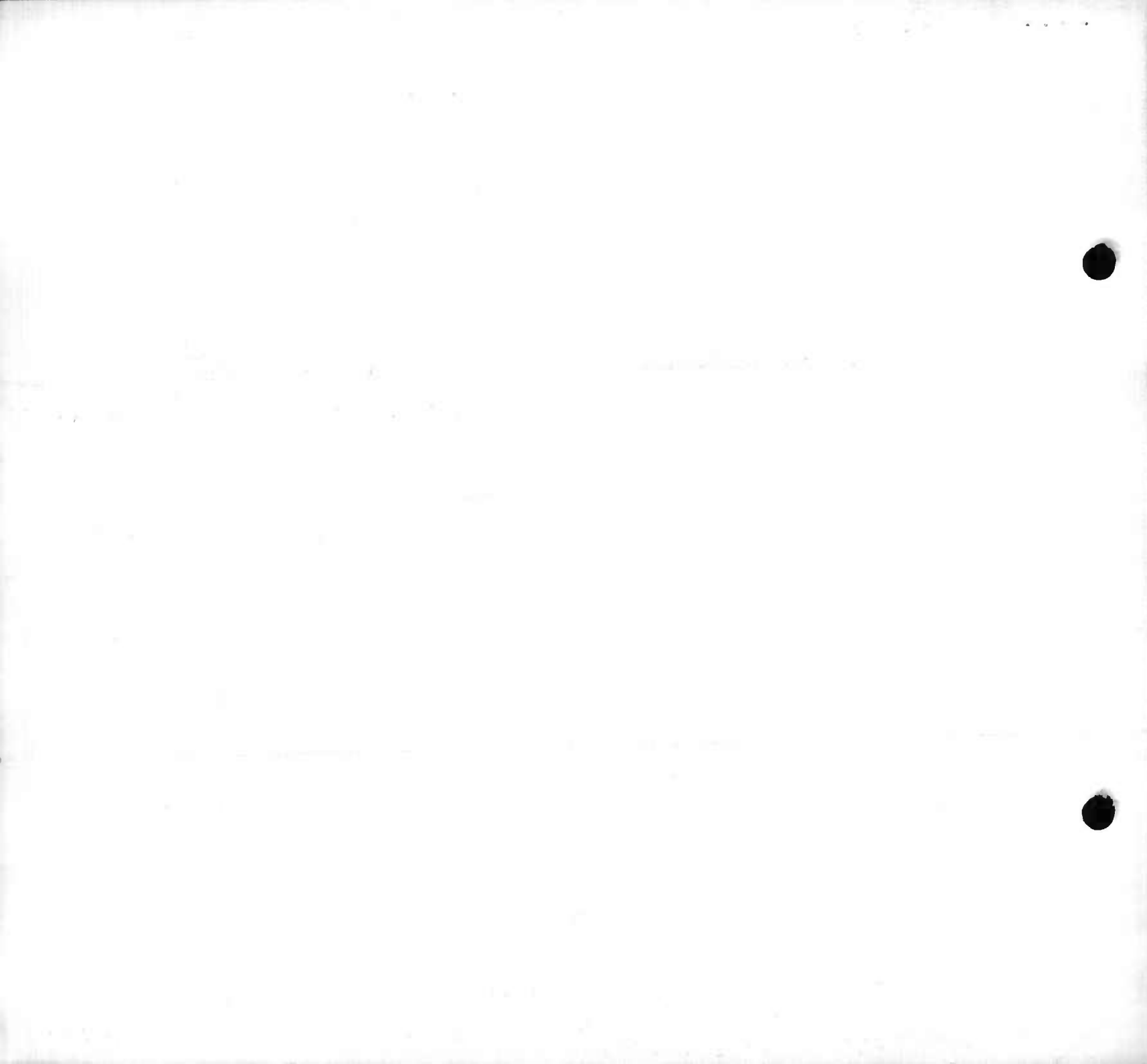
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|---|--|
| 71 0688 | | | | | 71 0688 | | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>REDDINGTON LAWRENCE</u> | | | | | 2. DATE AND HOUR OF DEATH <u>1/21/71</u> <u>4:30 A.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hosp.</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>13-07</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4121 Falls Rd.</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH <u>9/2/1896</u> | | 9. AGE (In years last birthday) <u>74</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd. Coll. Mgr.</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Blum's Dept. Store</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>William Reddington</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary A. Newman</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. <u>216-07-4701A</u> | | | | | |
| 17. INFORMANT <u>Mary L. Reddington</u> | | | | | ADDRESS <u>4121 Falls Rd.</u> | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412-41</u> CAUSE OF DEATH (A) <u>CARDIAC ARREST</u> (B) <u>CARDIAC CACHEXIA</u> (C) <u>ASCVD</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 YRS</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>71</u> to <u>1/21</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Juan M. Pardo</u> | | | | | 23B. DATE SIGNED <u>1/21/71</u> | | | 23C. PHYSICIAN'S NAME (Type) <u>JUAN M. PARDO</u> | | |
| 23D. ADDRESS <u>MGM Linden Ave Balto Md</u> | | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | |
| 24B. DATE <u>1/26/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Mary's Cem. - Govans</u> | | | 24D. LOCATION (City, town, or county) <u>Baltimore,</u> | | | 24E. STATE <u>Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | | 25B. NAME OF REGISTRAR <u>Rebecca Taylor</u> | | | 25C. FUNERAL DIRECTOR <u>Donovan Funeral Home</u> | | | ADDRESS <u>3818 Roland Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0689 | | REG. NO. 71 0689 | |
|---|-------------------------|---|--------------------------------------|---|------------------------------|---|--|
| BIRTH NO. <u>S-616</u> | | | | 71 0689 | | 71 0689 | |
| 1. NAME OF DECEASED (Type or Print) <u>SCARBOROUGH, JAMES R. Sr.</u> | | | | 2. DATE AND HOUR OF DEATH <u>1/18/1971 1125 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MD. GEN. HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>4204 Belmar Ave. # 06.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/23/1909</u> | 9. AGE (In years last birthday) <u>61</u> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>C & P Tel Co</u> | | 11. BIRTHPLACE (State or foreign country) <u>Harford Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>J. Oscar Scarborough</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emily B. Robinson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Eugenia E. Scarborough - 4204 Belmar Ave.</u> | | | |
| 18. <u>410.9 I</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ventricular Fibrillation</u> | | <u>25 min.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>1 mo</u> | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>2/1</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/26/71</u> 19 <u>71</u> to <u>1/18/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/18/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>M. S. AL-IBRAHIM M.D.</u> | | | | 23B. DATE SIGNED <u>1-18-1971</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>M. S. AL-IBRAHIM</u> | | | | 23D. ADDRESS <u>MD. Gen. Hospital.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-22-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>E. J. Taylor, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>John C. Oiler</u> | | 25D. ADDRESS <u>Inc-6415 Belair Rd. - 21206</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

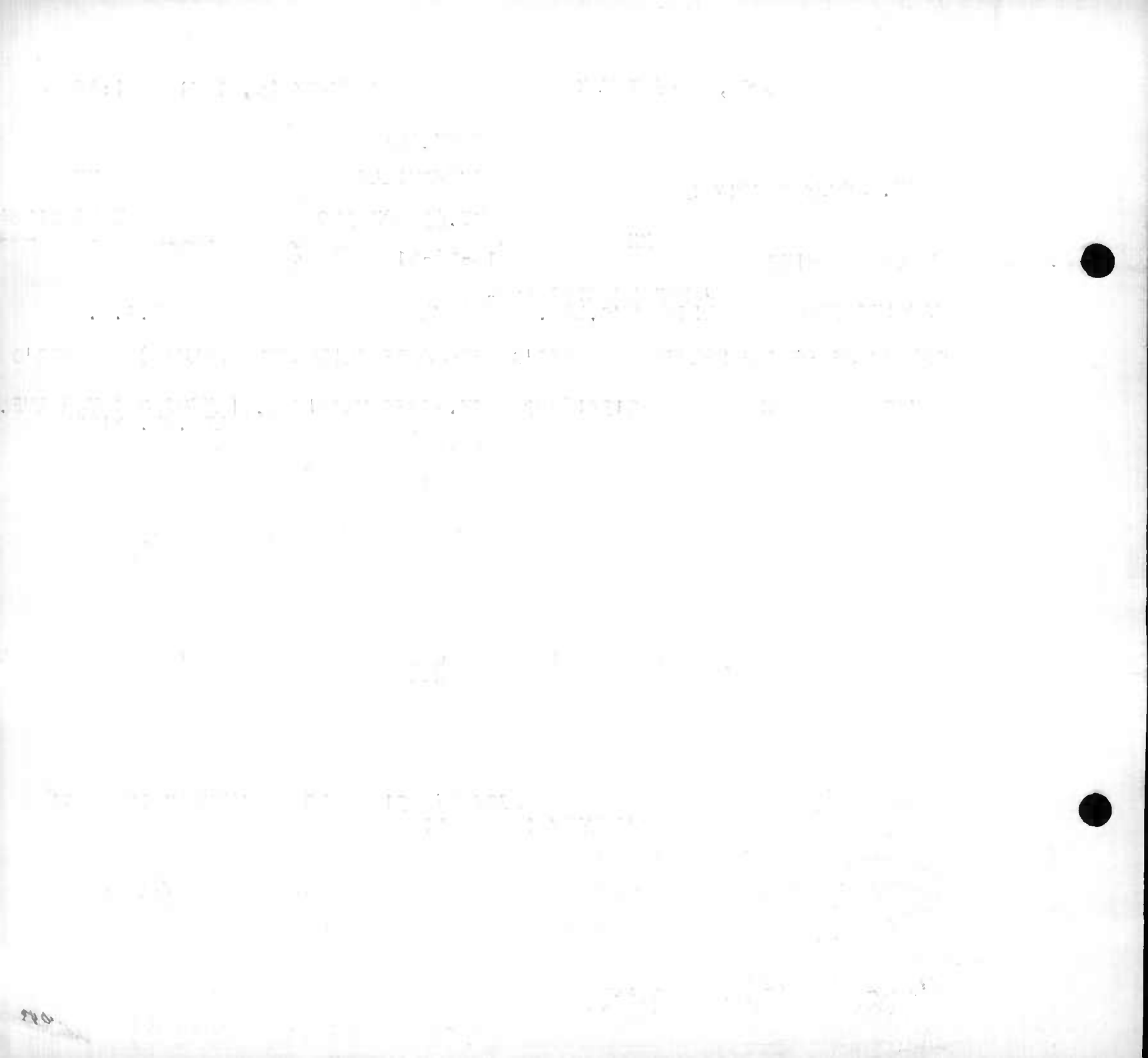
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0690 | |
|--|--|---|--|--|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Annie Kann | | 2. DATE AND HOUR OF DEATH 1/22/71 4³⁰ a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION House in the Pines - Belver. 90 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY 27-19 C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Belvedere Ave | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/4/1978 | | 9. AGE (In years last birthday) 92 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME — | | |
| 14. MOTHER'S MAIDEN NAME Lena | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. — | | | 17. INFORMANT Louis Kann | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Pneumonia | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C. V. A. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: general arteriosclerosis | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: — | | | 15 years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/1/1946 to 1/22/1971 that (I) (we) last saw the deceased alive on 1/22/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. S. Zinberg md | | | | 23B. DATE SIGNED 1/22/71 | |
| 23C. PHYSICIAN'S NAME (Type) J. S. ZINBERG | | | | 23D. ADDRESS 4000 W. NORTHERN Parkway | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/24/71 | | 24C. NAME OF CEMETERY or CREMATORY Balto Helens | |
| 24D. LOCATION (City, town, or county) Balto | | 24E. STATE md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR John E. ... | | 25C. FUNERAL DIRECTOR John & Son | |
| 25D. ADDRESS 9610 Reisterstown Rd | | 25E. CITY, TOWN, OR COUNTY — | | | |

2802 manhattan ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0691</u> | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. <u>P-456</u> | | 71 0691 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) PALMER, ALBERT MAX | | | 2. DATE AND HOUR OF DEATH JANUARY 19, 1971 1:30 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Cannell Co C. CITY OR TOWN SYKESVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RT. #3 BOX 320 ZONE 21784 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-26-21 | 9. AGE (In years last birthday) 49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY GUARD | | 10B. KIND OF BUSINESS OR INDUSTRY JOHNS HOPKINS APPLIED PHYS. LAB. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME CHANEY JEFFERSON PALMER DEC 'D | | | 14. MOTHER'S MAIDEN NAME FLORENCE ELIZABETH (PALMER) DEC 'D | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2 | | 16. SOCIAL SECURITY NO. 213016903 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. BALTO. MD. 21228 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 189.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Dissected Metastatic 23y Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | 19. DATE OF OPERATION 2 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21 | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 22. I certify that (1) (this hospital) attended the deceased from DECEMBER 31 1970 to JANUARY 19 1971 that (1) (we) last saw the deceased alive on JANUARY 19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Raymond D. Bahr | | | 23B. DATE SIGNED 1/19/71 | | 23C. ADDRESS ST Agnes |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-23-71 | | |
| 24C. NAME OF CEMETERY OR CREMATORY Good Shepherd | | | 24D. LOCATION (City, town, or county) (State) Ellicott City, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | |
| 25C. FUNERAL DIRECTOR Highbottom & Slack F.H. | | | 25D. ADDRESS Ellicott City Md 21043 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0692 | |
|---|---------------------------|---|---|---|--|
| <div style="display: flex; justify-content: space-between;"> G-654 71 0692 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Greenwalt, Edith H. | | 2. DATE AND HOUR OF DEATH 1/21/71 2:40 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION House In The Pines, 2525 W. Belvedere Ave House In The Pines 2525 W Bel. Ave. | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Randallstown 21133 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 9004 Wilbur Avenue, | | | |
| 5. SEX F | 6. RACE white w | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-3-1904 | 9. AGE (in years last birthday) 66 66 | 11. BIRTHPLACE (State or foreign country) Maryland |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY Nursery School | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Patrick Henry Haviland | | | 14. MOTHER'S MAIDEN NAME Mary -- Creaghan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-20-1394A | | 17. INFORMANT ADDRESS Randallstown, Md. 21133 Arthur A. Greenwalt, 9004 Wilbur Avenue | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma Lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Months (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1969 to Jan 21 1971 that (I) (we) last saw the deceased alive on Jan 12 1971 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David I. Miller M.D. | | | | 23B. DATE SIGNED Jan 21-71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| David I. Miller M.D. | | 9115 Keisterstown Rd. Owings Mills Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/23/71 | | Druid Ridge Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 25 1971 | | Charles E. Miller, Jr. | | Loring Byers, 8728 Liberty Rd. Randallstown, | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0693 |
|---|----------------------------|--|---------------------------------------|--|
| G-230 71 0693 CERTIFICATE OF DEATH | | | | REG. NO. 71 0693 |
| BIRTH NO. <u>G-230</u> | | 1. NAME OF DECEASED (Type or Print) <u>MELVIN W. GAST</u> | | |
| 2. DATE AND HOUR OF DEATH <u>22 JAN 1971 11:28 A.M.</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>SOUTH BALTO. GEN. HOSP.</u> | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>25-34</u> | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 SOUTH BALTO. GEN. HOSP.</u> | | |
| 6. CITY OR TOWN <u>BALTO.</u> | | 7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 8. STREET AND NUMBER <u>3903 5th St.</u> | | | | |
| 9. SEX <u>M</u> | 10. RACE <u>W</u> | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12. DATE OF BIRTH <u>13 MAY 08</u> | 13. AGE (In years last birthday) <u>62</u> |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ESTIMATOR</u> | | 15. KIND OF BUSINESS OR INDUSTRY <u>SHIP BUILDING</u> | | 16. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |
| 17. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 18. FATHER'S NAME <u>WALTER GAST</u> | | |
| 19. MOTHER'S MAIDEN NAME <u>LENA STINDT</u> | | 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u> | | |
| 21. SOCIAL SECURITY NO. | | 22. INFORMANT ADDRESS <u>HOSPITAL CHART</u> | | |
| 23. CAUSE OF DEATH <u>MYOCARDIAL INFARCTION</u> | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> | | |
| 25. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROSIS</u> | | 26. (B) DUE TO, OR AS A CONSEQUENCE OF: <u>YEARS</u> | | |
| 27. (C) DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS</u> | | 28. YEARS <u>YEARS</u> | | |
| 29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> | | | | |
| 30. DATE OF OPERATION <u>0</u> | | 31. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 32. AUTOPSY? (Yes or No) <u>NO</u> |
| 33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 36. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 37. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 38. HOW DID INJURY OCCUR? |
| 39. I certify that (I) (this hospital) attended the deceased from <u>12 JAN 1971</u> to <u>22 JAN 1971</u> that (I) (we) last saw the deceased alive on <u>22 JAN 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 40. SIGNATURE <u>Gary A. Belaga, M.D.</u> | | 41. DATE SIGNED <u>22 JAN 1971</u> | | 42. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |
| 43. PHYSICIAN'S NAME (Type) <u>GARY A. BELAGA, M.D.</u> | | 44. ADDRESS <u>3001 S. HANOVER ST.</u> | | |
| 45. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 46. DATE <u>1/25/71</u> | 47. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 48. LOCATION <u>Baltimore Md.</u> | (State) |
| 49. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 50. NAME OF REGISTRAR <u>John E. Talbot</u> | | 51. FUNERAL DIRECTOR <u>McQuay Funeral Home Balto. Md. 21225</u> |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0694

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) REGINAL RAILY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 20 1971 12:15 a M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8-15-35 | | 10. AGE (In years lost birthday) 35 | |
| 11. BIRTHPLACE (State or foreign country) BALTO, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HYLAND RAILEY | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 13-02 | |
| 15. MOTHER'S MAIDEN NAME MARJORIE RAILEY | | 16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | |
| 17. SOCIAL SECURITY NO. 219-30-1504 | | 18. INFORMANT WILNET RAILEY | |
| 19. CAUSE OF DEATH Hypertensive cardiovascular disease | | 20. ADDRESS 2319 EUTAW PLACE | |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease | | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 24. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) _____ (B) _____ (C) _____ | |
| 25. DATE OF OPERATION 1-23-71 | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 29. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 32. HOW DID INJURY OCCUR? | |
| 33. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 34. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| 35. ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | 36. DATE SIGNED 1-20-71 | |
| 37. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | 38. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 39. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | 40. FUNERAL DIRECTOR Westport BALTO. P.D. | |
| 41. BURIAL CREMATION, REMOVAL (Specify) Burial | | 42. DATE 1-23-71 | |
| 43. NAME OF CEMETERY or CREMATORY MT. AUBURN | | 44. LOCATION (City, town, or county) (State) Westport BALTO. P.D. | |
| 45. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 46. NAME OF REGISTRAR Robert E. [Signature] | |
| 47. FUNERAL DIRECTOR Westport BALTO. P.D. | | 48. ADDRESS 1922 Edmond St. [Signature] | |

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THE UNIVERSITY OF CHICAGO

ACADEMY OF BIOLOGY

THE JOURNAL

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1880

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

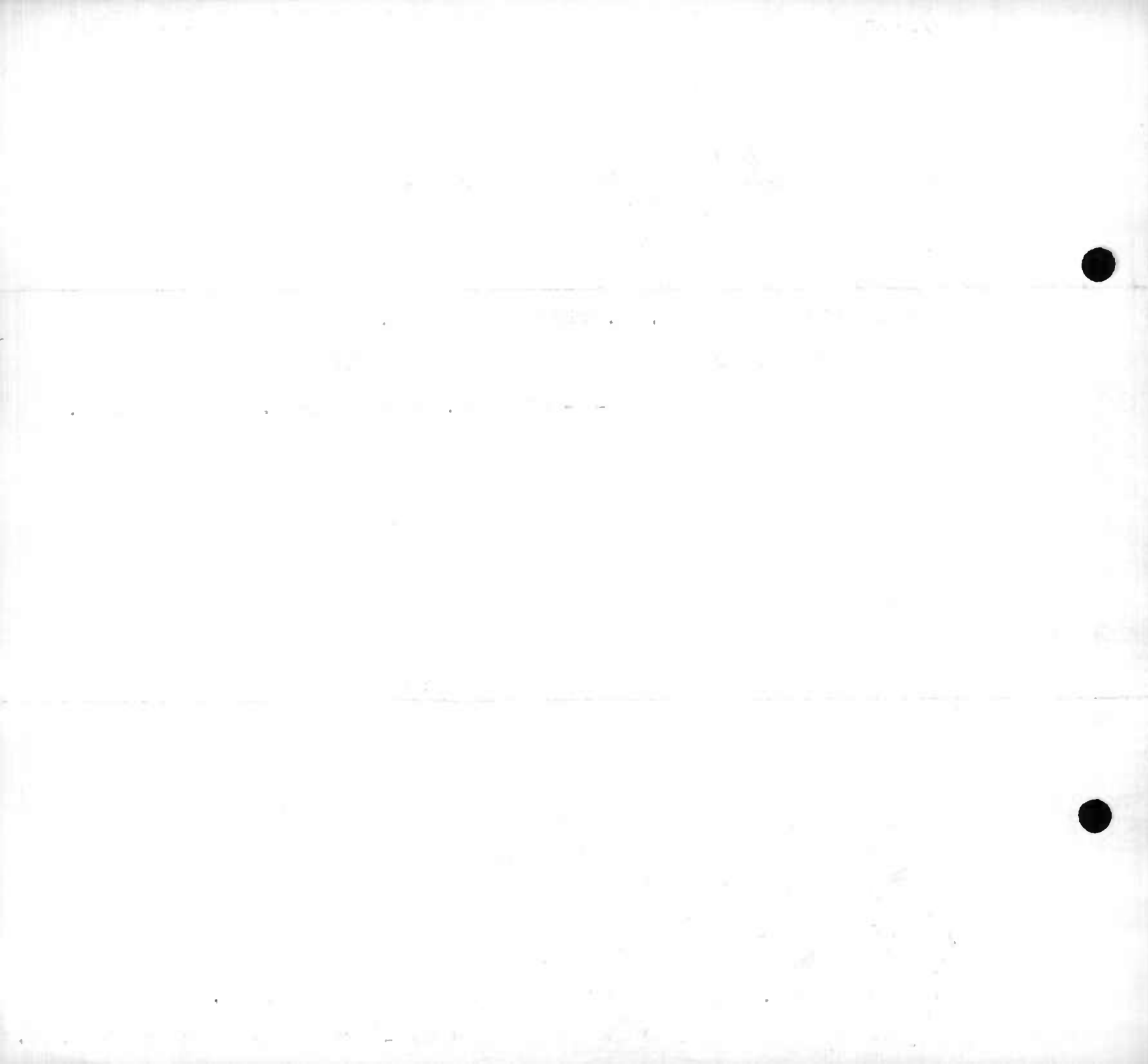
| Baltimore City Health Department CERTIFICATE OF DEATH | | | | REG. NO. [REDACTED] | |
|---|----------------------------|--|---|---|---|
| BIRTH NO. <div style="font-size: 1.5em; font-weight: bold;">E-610 71 0695</div> | | <div style="text-align: right; font-size: 1.5em; font-weight: bold;">71 0695</div> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>LEON L. ERB</u> | | | 2. DATE AND HOUR OF DEATH <u>1-18-71</u> <u>9:15 P. M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 Union Memorial Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-48</u> C. CITY OR TOWN <u>Baltimore</u> D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4114 Buena Vista Avenue</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-7-91</u> | 9. AGE (in years last birthday) <u>79</u> | 10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cloth Examiner</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Textile</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 13. FATHER'S NAME <u>Joseph Erb</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sylvia Duce</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>212035029</u> | | |
| 17. INFORMANT <u>Mrs Jane Erb</u> | | | ADDRESS <u>same</u> | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Lung Abscess</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Postum Alcoholic</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-16</u> 19<u>71</u> to <u>1-18</u> 19<u>71</u> that (I) (we) last saw the deceased alive on <u>1-18</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>In Napiza</u> | | | 23B. DATE SIGNED <u>1-18-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>MARIELY NAPIZA M.D.</u> |
| 23D. ADDRESS <u>Union Memorial Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>22 JAN 71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St Mary's Cem</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Roland Ave Balto Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u> | | 25C. FUNERAL DIRECTOR <u>Burges Funeral Home Balto Md</u> | |

100-100000



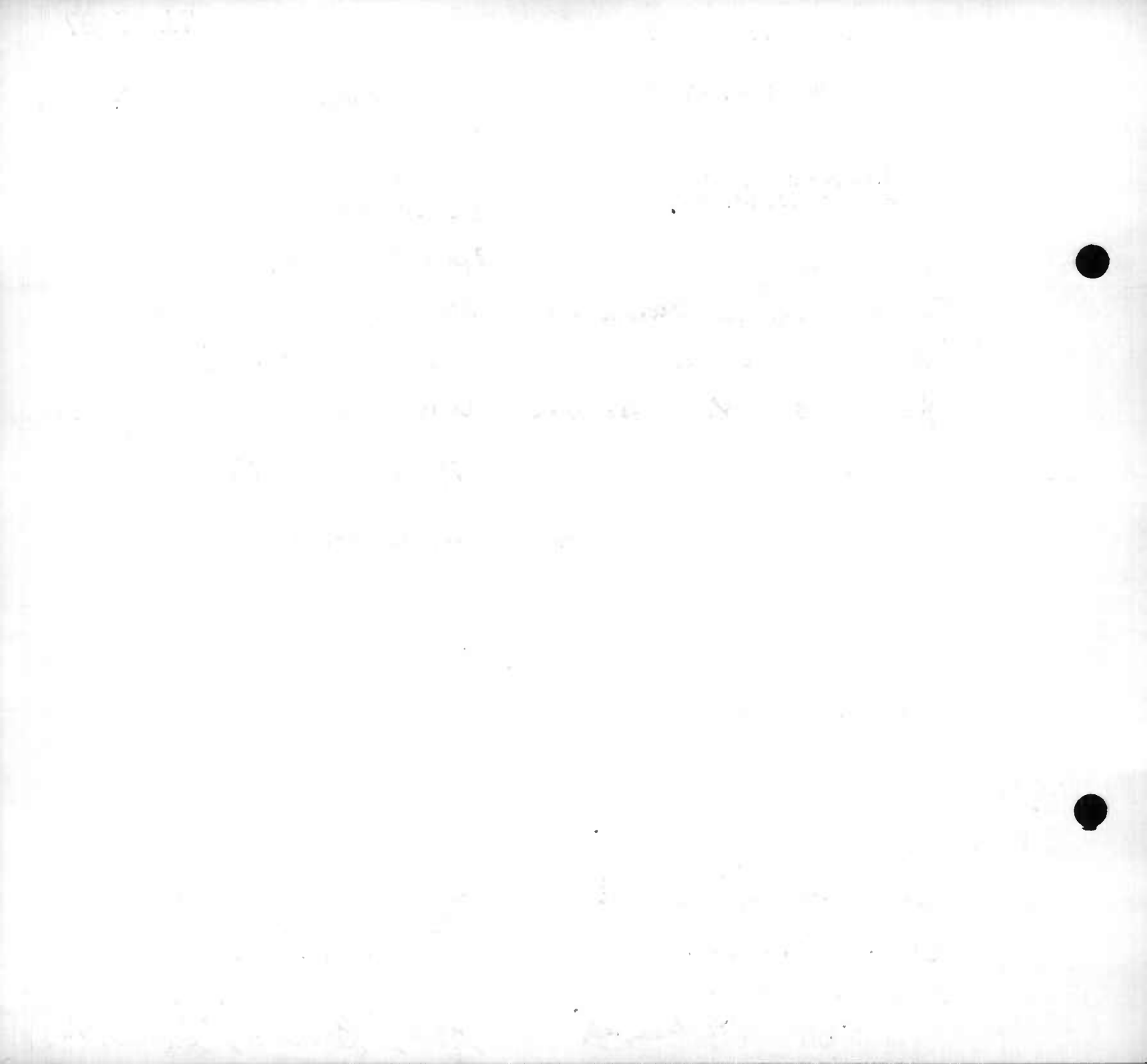
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

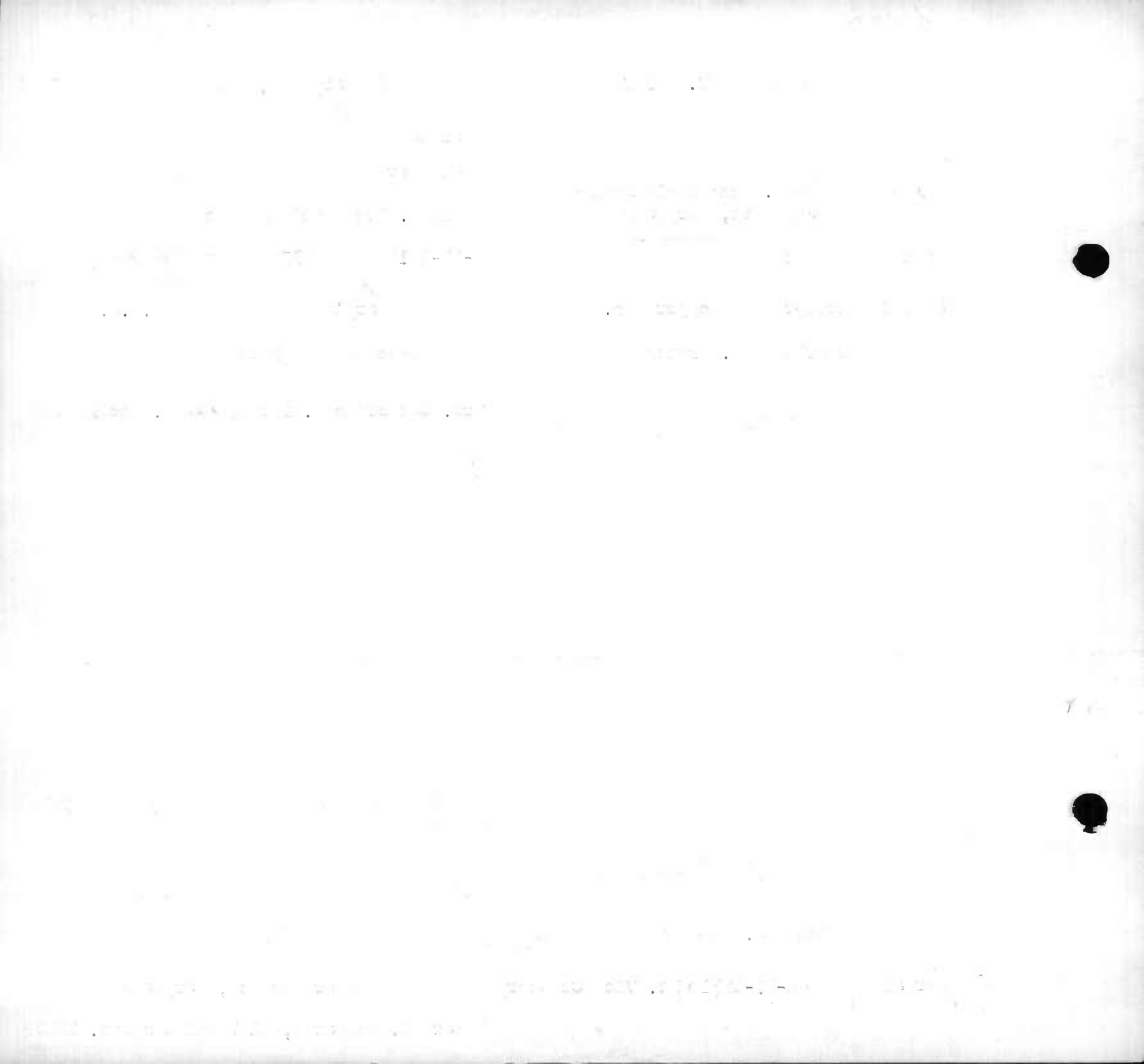
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0697 | |
|---|-----------------------|---|---|---|---|
| CERTIFICATE OF DEATH | | | | 71 0697 | |
| BIRTH NO. 17-626 71 0697 | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) FRANCIS B. MERCIER | | | 2. DATE AND HOUR OF DEATH January 20, 1971 12:10 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) U.S. Army Health Clinic Ft Holabird, Md. 21219 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Germany B. COUNTY V-L-65 | | |
| | | | C. CITY OR TOWN Worms | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 22 Von Steuben Strasse | | |
| 5. SEX Male | 6. RACE Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 13, 1919 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service Employee | | 10B. KIND OF BUSINESS OR INDUSTRY Government | | 11. BIRTHPLACE (State or foreign country) Massachusetts | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME William Mercier | | | |
| 14. MOTHER'S MAIDEN NAME Eunice Robinson | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1938 - 1961 | | | |
| 16. SOCIAL SECURITY NO. 458-46-1361 | | 17. INFORMANT Wife | | | |
| 18. CAUSE OF DEATH 410.9 I | | 19. ADDRESS Siesta Motel 8100 Pulaski Highway Baltimore | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Coronary Thrombosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Neil H. Kolsky M.D. | | | | 23B. DATE SIGNED 20 Jan 1971 | |
| 25C. PHYSICIAN'S NAME (Type) NEIL H. KOLSKY, MAJ. MC. | | | | 25D. ADDRESS US Army Health Clinic Ft Holabird, Md. 21219 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/21/71 | | 24C. NAME OF CEMETERY OR CREMATORY LANGE FUNERAL HOME DOURDANTON, TEXAS | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Robert E. Taylor | |
| 25D. ADDRESS Seaside Ph. Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

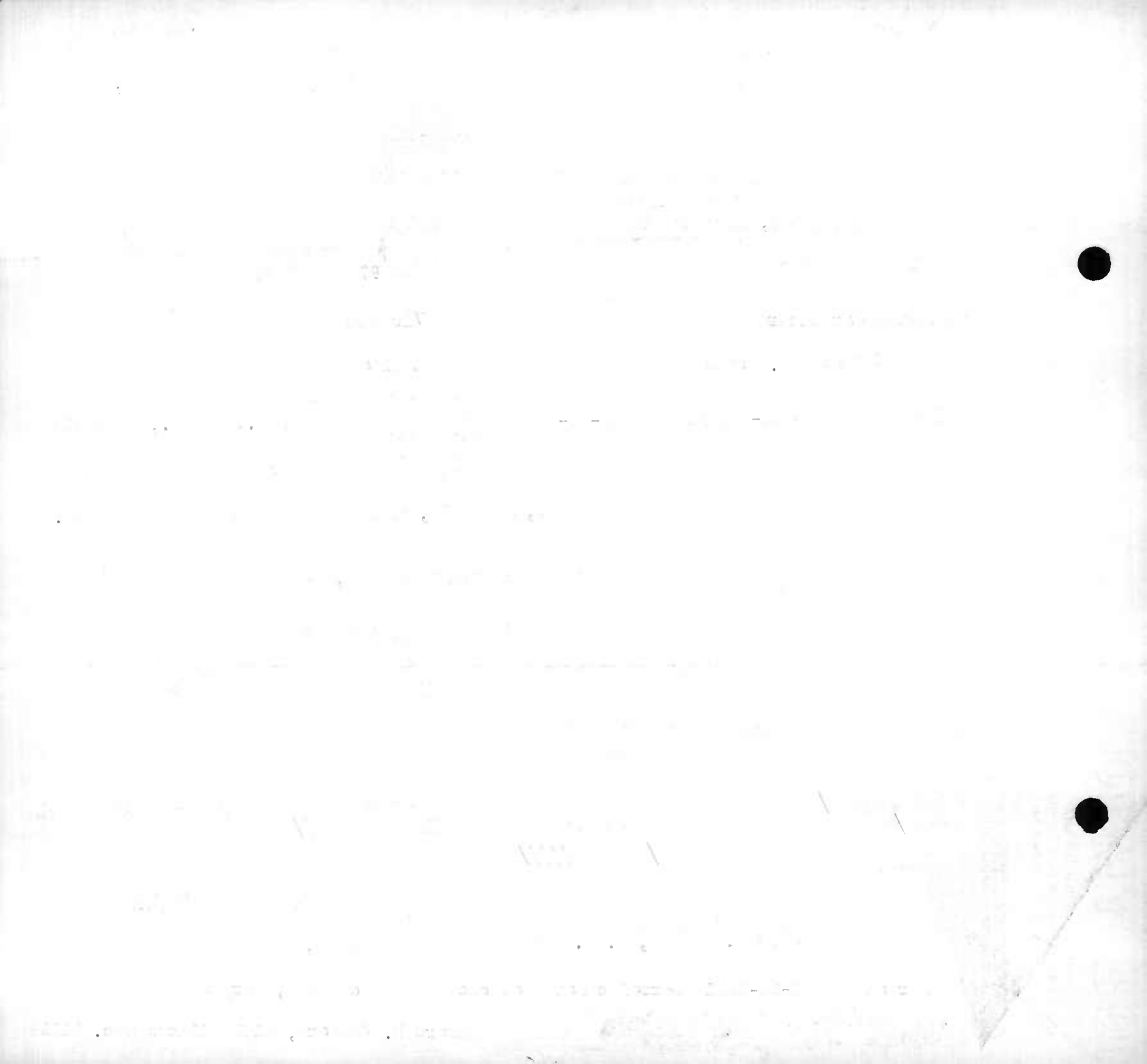
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0698 | | REG. NO. 71 0698 | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. P-320 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) LEONARD T. POTTS | | | | 2. DATE AND HOUR OF DEATH January 19, 1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| 00 | | 411 S. Beechfield Avenue Baltimore, Maryland | | Maryland | | 25-41 | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 411 S. Beechfield Avenue | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8-22-1913 | |
| | | | | | | 9. AGE (in years lost birthday) | |
| | | | | | | 57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Machine Operator | | | | Koppers Co. | | Maryland | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Charles E. Potts | | | | Rose Abbey Porter | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | | | ADDRESS | |
| | | | | | | Mrs. Catherine R. Potts, 411 S. Beechfield | |
| 18. CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Lung</i> | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| (B) <i>metastases to liver</i> | | | | | | | |
| (C) _____ | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 1970</i> to <i>Jan 19 1971</i> that (I) (we) last saw the deceased alive on <i>Jan 18 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| <i>Leon A. Kochman</i> | | | | 1-20-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Leon A. Kochman | | | | M.D. 1214 N. Calvert ST | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 1-23-1971 | | Mt. View Cemetery | | Howard County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 25 1971 | | 000000 | | Howard H. Hubbard | | 4107 Wilkens Ave. 21229 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0699 | | 71 0699 | |
|---|--|--|--|--|--|---|--|
| BIRTH NO. D-120 | | | | 71 0699 | | 71 0699 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | 71 0699 | |
| DAVIS, CHARLES H | | | | 1/17/71 | | 10:30 P | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | Maryland | | Baltimore Co. 53-00 | |
| Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | | C. CITY OR TOWN White Hall | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER Box 246 | | | | 5. SEX | | 6. RACE | |
| Male | | | | White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH | | | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | |
| 4/16/97 | | | | 78 73 | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired Carpenter | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Thomas W. Davis | |
| 14. MOTHER'S MAIDEN NAME Lillian | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10/25/18-6/18/19 | | 16. SOCIAL SECURITY NO. 217-07-8180 | |
| 17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto, Md 21218 | | | | ADDRESS | | 18. CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Peritonitis due to perforation of colon, cause unclear | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 Days | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Emboli, multiple, pulmonary bilateral | | 3 Days. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: Chronic ulcers massive, decubitus operated | | Years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Chronic brain damage due to arteriosclerosis | | Years | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 30th 19 70 to January 17th 19 71 that (I) (we) last saw the deceased alive on January 17th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Donald H. Hooker, M. D. | | | | 1/18/71 | | 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | | | 1-21-1971 | | Lorraine Park Mausoleum | |
| 24D. LOCATION (City, town, or county) (State) | | | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| Woodlawn, Maryland | | | | JAN 25 1971 | | Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

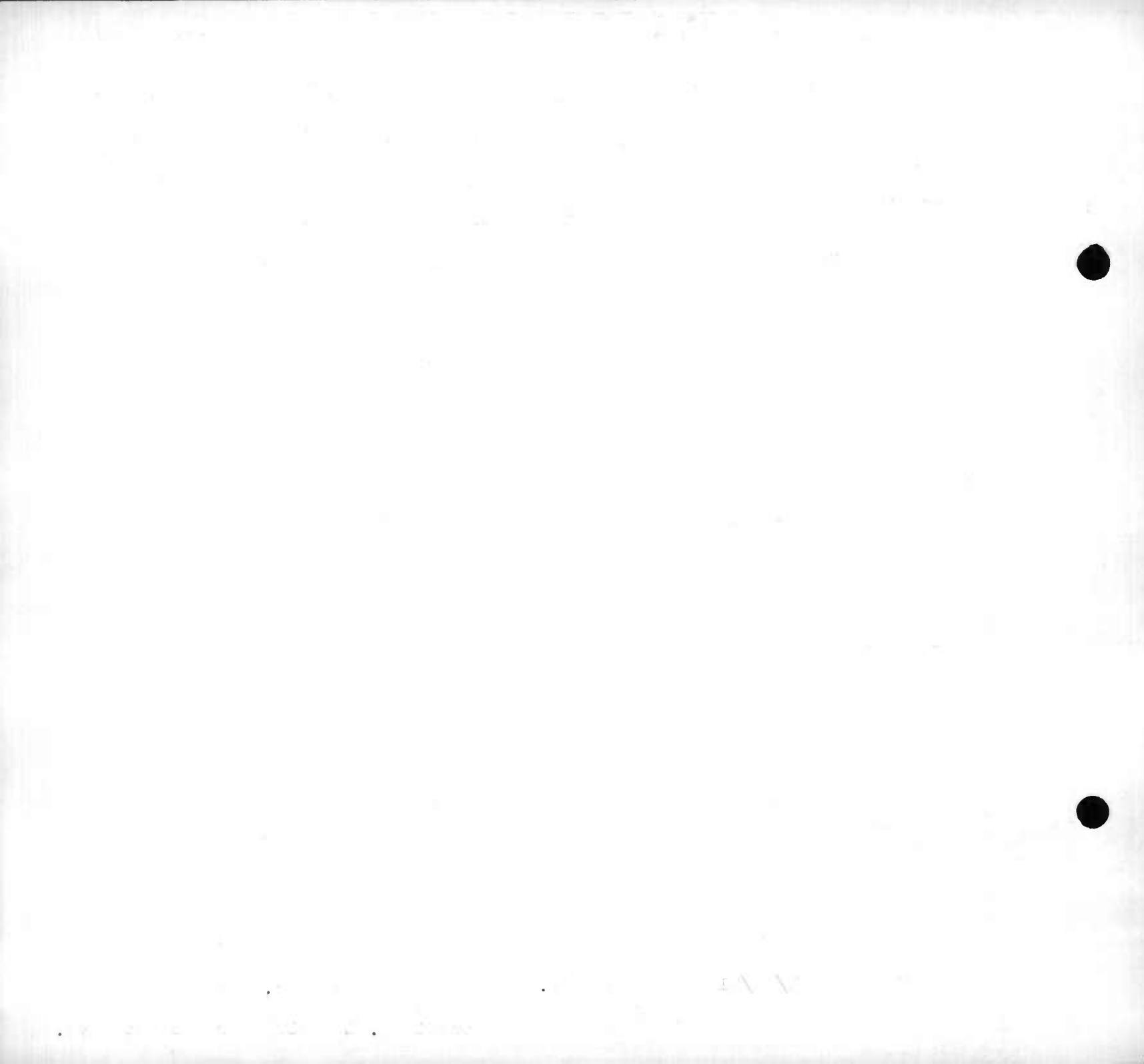
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. [REDACTED] 0700 | |
|---|--|---|--|---|--|
| G-653 71 0700 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>BARBARA GRANT</i> | | 2. DATE AND HOUR OF DEATH <i>1-21-71 7:45 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Union Memorial Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-11</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>F</i> | | 6. RACE <i>W</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <i>5-11-93</i> | | 9. AGE (in years last birthday) <i>78</i> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>not known</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.B</i> | | 13. FATHER'S NAME <i>not known</i> | | 14. MOTHER'S MAIDEN NAME <i>not known</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Hosp. Records</i> | |
| 18. <i>431.9 I</i> CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i> | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>1-23-71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>1-25</i> 19 <i>71</i> to <i>1-21</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>1-21</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Mariely Napiza</i> <i>MARIELY NAPIZA</i> | | 23B. DATE SIGNED <i>1-21-71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>MARIELY NAPIZA</i> | |
| 23D. ADDRESS <i>Union Memorial Hospital</i> | | 23E. ATTENDING PHYSICIAN M.D. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23F. DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>1-23-71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Loxden Park Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore - Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>McCall</i> | | 25D. ADDRESS <i>30 E. Fort Ave.</i> | | 25E. DATE <i>1-25-71</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0701 | |
|--|-------------------------|---|--|---|--|
| BIRTH NO. W-452 71 0701 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Williams, Randolph | | 2. DATE AND HOUR OF DEATH 1/19/71 11:20 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 2319 Garrett Ave. | | | |
| 5. SEX Male | 6. RACE Black | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 01-27-21 | 9. AGE (In years last birthday) 49 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Robert Williams | | 14. MOTHER'S MAIDEN NAME Hannah Johnson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Bessie Williams ADDRESS Same | |
| 18. 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive upper gastro-intestinal hemorrhage due to rupture of esophageal varices of cirrhosis etiology | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rostrum Alcohol | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/19 19 71 to 1/19 19 71 and that (I) (we) last saw the deceased alive on 1/19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. Earl Cotman, M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/19/71 | |
| 23C. PHYSICIAN'S NAME (Type) H. Earl Cotman, M.D. | | 23D. ADDRESS Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/23/71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Valenzuela | | 25C. FUNERAL DIRECTOR Kenneth H. Law ADDRESS 4609 Park Heights Ave. | |



1

Q-500

71

0702

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

0702

BIRTH NO.

REG. NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) STEVEN QUEEN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 22 1971 6:40 a M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 27-16 | |
| 9. DATE OF BIRTH Mar 12, 1950 | | 10. AGE (In years, last birthday) 20 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Bernard Queen | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | |
| 15. MOTHER'S MAIDEN NAME Chloe Bond | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 216-50-2289 | | 18. INFORMANT ADDRESS Chloe McDowell, 3016 Dupont Ave. Apt. #3 | |
| 19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Narcotics addiction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-22-71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Sanders, Jr. | |
| 25C. FUNERAL DIRECTOR Kenneth H. Law | | ADDRESS 4609 Park Heights Ave | |

ACADEMY BOND

RECEIVED

VALLEY PARK, TN

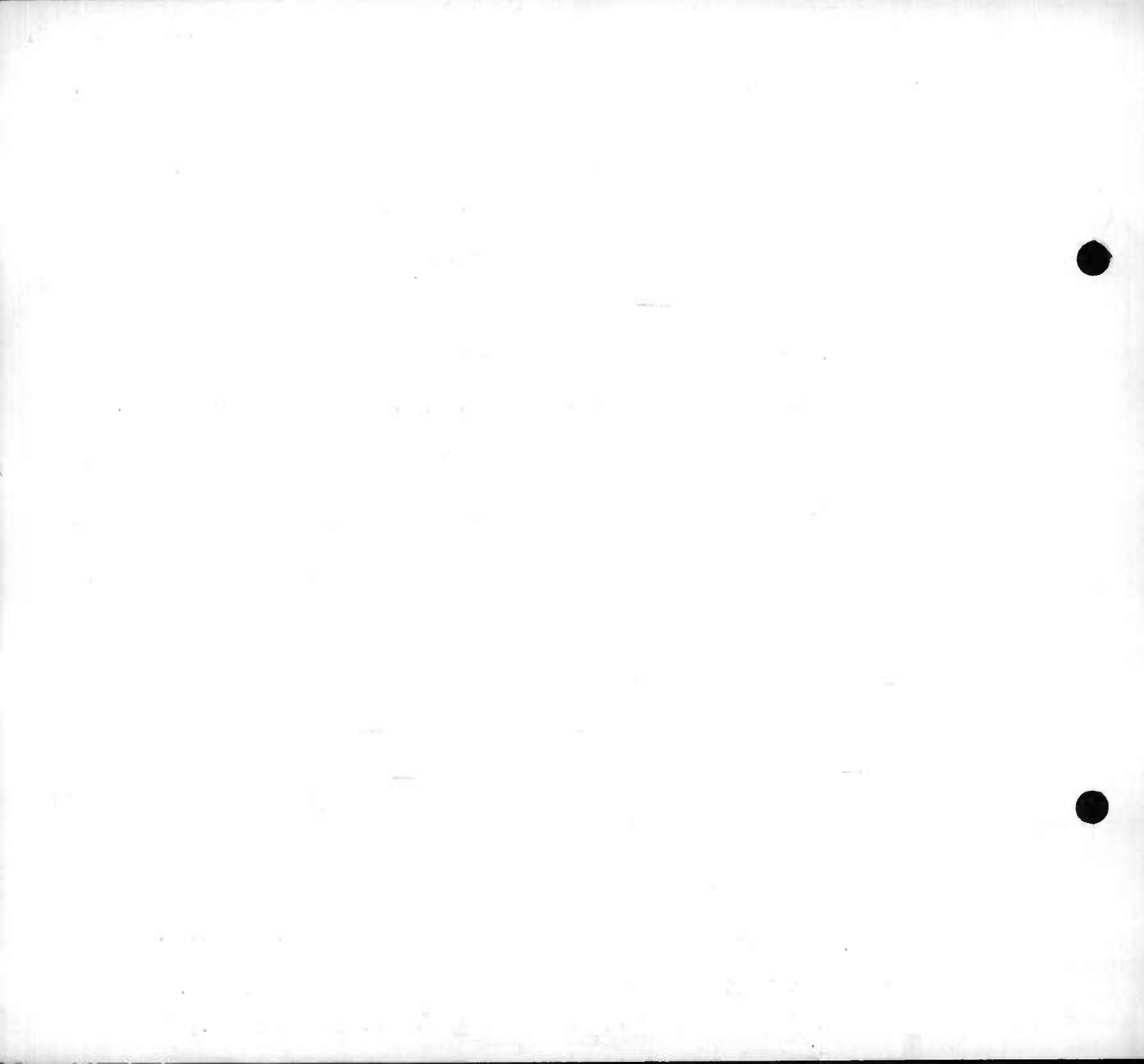
FEB 2 1971

11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0703 | |
|--|--|--|--|---|--|
| M-460 71 0703 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| Alice Eugenia Mueller | | January 22, 1971 6:50 P.M. | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| 5500 Frederick Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. SEX | |
| Md | | 6. DATE OF BIRTH | | 7. RACE | |
| C. CITY OR TOWN | | 5/9/1880 | | White | |
| Baltimore | | 8. AGE (In years last birthday) | | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| D. INSIDE CITY LIMITS? | | 90 | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 10. BIRTHPLACE (State or foreign country) | | 11. FATHER'S NAME | |
| 5500 Frederick Avenue | | Maryland | | Joseph J. Hooper | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. MOTHER'S MAIDEN NAME | | 14. Was Deceased Ever in U. S. Armed Forces? | |
| USA | | Mary Virginia Lightner | | (Yes, no or unknown) (If yes, give war or dates of service) | |
| 15. SOCIAL SECURITY NO. | | 16. INFORMANT | | 17. ADDRESS | |
| 216-65-1328 | | Mrs. J. W. Wolf, 5500 Frederick Ave. | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | 10 Min | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | 20 years | |
| ANTECEDENT CAUSES | | | | 20 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | None | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| no | | no | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| no | | no | | no | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| no | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | no | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 19 1964</u> to <u>1/22/ 1971</u> that (I) (we) last saw the deceased alive on <u>1/22/ 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Dr. Cliff Batliff | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Cliff Batliff | | | | 4605 Edmondson Ave., Balto. Md. | |
| 24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial 1/26/71 | | Western | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 25 1971 | | Robert E. Z... | | Witzke, 1630 Edmondson Ave., 21228 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0704 | |
|--|--|--|--|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) JORDAN, CLARA | | 2. DATE AND HOUR OF DEATH 1/23/71 1.25 A. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTO., INC. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-16 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4669 Park Heights Ave. #15 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/13/39 | 9. AGE (in years last birthday) 32 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. 43691 CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ① CVA ② pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/22/1971 to 1/23/1971 that (I) (we) last saw the deceased alive on 1/23/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Vichai Atichartakarn, M.D. | | | | 23B. DATE SIGNED 1/23/71 | |
| 23C. PHYSICIAN'S NAME (Type) VICHAI ATICHARTAKARN, M.D. | | 23D. ADDRESS SINAI HOSP. OF BALTO., INC. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| JAN 25 1971 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 0705 | |
| CERTIFICATE OF DEATH | | REG. NO. 71 0705 | |
| 1. NAME OF DECEASED (Type or Print) MARY A. WILLIAMS | | 2. DATE AND HOUR OF DEATH 1-20-71 12:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 5-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL BALTO.-MD. 21231 | | C. CITY OR TOWN BALTIMORE | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER 125 N. CALVIN | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-2-06 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 65 |
| 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S. 0705 | |
| 13. FATHER'S NAME JOHN ROBINSON | | 14. MOTHER'S MAIDEN NAME CARRIE HENNING | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT LILIAN JOHNSON (DAUGHTER) | | ADDRESS | |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH CONGESTIVE HEART FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular years (B) DUE TO, OR AS A CONSEQUENCE OF: disease (C) Bronchitis, Acute | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 20 - 1971 to 19 that (I) (we) last saw the deceased alive on DOA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Manuel A. Gongon, M.D. | | 23B. DATE SIGNED 1-20-71 | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL A. GONGON, M.D. | | 23D. ADDRESS CHURCH HOME & HOSPITAL | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem | | 24D. LOCATION (City, town, or county) (State) Anne Arundel City Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Philip E. [Signature] | |
| 25C. FUNERAL DIRECTOR Wm. C. March | | ADDRESS 928 E. North Ave | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|---|------------------------------------|--|---|
| L-520 71 0706 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0706 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Thomas Lynch SR</i> | | 2. DATE AND HOUR OF DEATH <i>1-21-71 3:35 pm</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp. of Maryland</i> | | A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN <i>15-10</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER <i>3838 Boorman Ave.</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>N.C.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>2-13-08</i> | 9. AGE (In years last birthday) <i>62</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>N.C. (USA)</i> | |
| 13. FATHER'S NAME <i>SILAS LYNCH</i> | | 14. MOTHER'S (MAIDEN NAME) <i>ELLA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA citizen</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>212-16-3469</i> | | 17. INFORMANT <i>MRS. ANNIE LYNCH</i> | |
| 18. <i>1529 I</i> | | CAUSE OF DEATH | | ADDRESS <i>AVE</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Intestinal obstruction</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sick for 26 days</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Carcinoma of pancreas.</i> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) <i>Pulmonary Embolism.</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>1-19-71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intest. Obstruction</i> | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-8-1971</i> to <i>1-21-1971</i> that (I) (we) last saw the deceased alive on <i>1-21-1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Gakuba</i> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>1-21-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>CHRYSOLOGUE GAKUBA, M.D.</i> | | 23D. ADDRESS <i>730, ASHBURTON ST. - Lutheran Hosp. of Maryland</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 24B. DATE <i>1/26/71</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>CHURCH MEM PR</i> | | 24D. LOCATION (City, town, or county) (State) <i>LAUREL MD.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1971</i> | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | 25C. FUNERAL DIRECTOR <i>Wm. C. March</i> | | ADDRESS <i>928 E. North Ave</i> | |

ORIGINAL OF 18 OCTOBER 1950

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) CHARLES JOHNSON, JR. | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital 2-16-71 | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 22 1971 12:48 a.m. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 10-02 | |
| 9. DATE OF BIRTH 1-22-53 | | 10. AGE (In years lost birthday) 18 | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME CHARLES T. JOHNSON | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME JUNE GRIFFIN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT JUNE JOHNSON 519 CHATEAU AVE | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9661X | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Stab wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | |
| 20. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) alley | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Madison & Ensor Sts. 10-02 | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY 1-22-71 a.m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Stabbed during altercation. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-26-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF HEALTH DEPT. N873.71 | |
| 25C. FUNERAL DIRECTOR Wm C. March | | 25D. ADDRESS 928 E North Ave | |

ACADEMY BOND

ACADEMY BOND

ACADEMY BOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

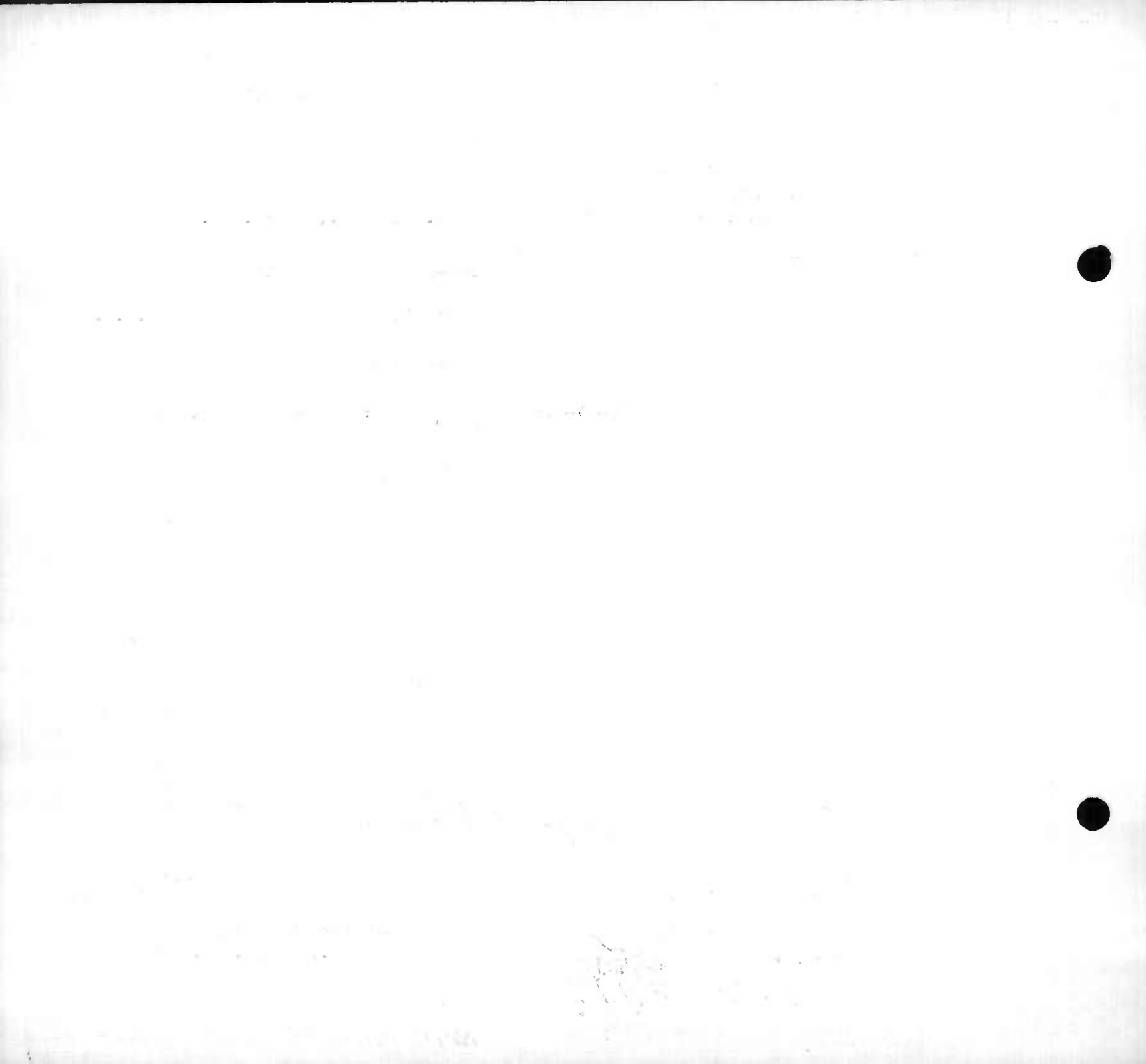
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0708</u> | |
|--|---------------------|---|---|--|---|
| BIRTH NO. <u>B-623</u> | | 71 0708 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>BRIGHT, WILLIAM F.</u> | | | 2. DATE AND HOUR OF DEATH <u>6:45 AM 1-23-71</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Maryland</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>20-01</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>1501 Dukeland St. Dukeland Nursing Home</u> | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/28/04</u> | 9. AGE (In years last birthday) <u>66 yrs</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IN STEEL FACTORY</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>VA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | |
| 13. FATHER'S NAME <u>WILLIAM FRANKLIN BRIGHT</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARIAM THROWER</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-09-5322</u> | | 17. INFORMANT <u>HARRY BRIGHT 1829 Penrose Avenue</u> | |
| 18. <u>736.71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTICAEMIA.</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>URINARY TRACT INFECTION</u> | | | |
| (B) <u>old CVA with Residual Hemiparesis</u> DUE TO, OR AS A CONSEQUENCE OF: | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>-</u> | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>1-21-1971</u> to <u>1-23-1971</u> that (1) (we) last saw the deceased alive on <u>1-23-1971</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Amayin memon M.D.</u> | | | | 23B. DATE SIGNED <u>1-23-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>A. MAJID MEMON M.D.</u> | | 23D. ADDRESS <u>Lutheran Hospital of Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1/27/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>CARYE MEM PARK</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>LAUREL MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>John E. Talbot</u> | | 25C. FUNERAL DIRECTOR <u>D. M. MARCH</u> | |
| ADDRESS <u>928 E. NORTH</u> | | | | | |

1829 Denrose Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0709 | |
|--|---------------|--|-------------------------|--|--|
| BIRTH NO. 625-71 0709 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Jesse Carson | | 2. DATE AND HOUR OF DEATH 1-20-71 8:30 a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-08 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 734 E. 21st St., Balto. Md. 20218 | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-6-18 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Georgia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Robert Carson | | | |
| 14. MOTHER'S MAIDEN NAME Leila Gouch | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 260-07-4353 | | 17. INFORMANT BCH Records 4940 Eastern Avenue Baltimore, Md. 21224 | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Malignant Cerebration Carcinoma Esophagus, Stomach Tracheal, Mediastinal invasion | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (it) (this hospital) attended the deceased from 10/8/70 to 1-20-71 that (I) (we) lost saw the deceased alive on 1/20/71 at 8:30 pm and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE P. Seshachary MD | | 23B. DATE SIGNED 1/20/71 | | 23C. PHYSICIAN'S NAME (Type) P. SESHACHARY | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/27/71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) Balto. Md. | | 24E. ADDRESS 4940 Eastern Ave., Balto. Md. 21224 | | 24F. FUNERAL DIRECTOR 928 E. North Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR 928 E. North Ave | |



Z-520 71 0710

BALTIMORE CITY HEALTH DEPARTMENT

71 0710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Anthony (Antoni) Zaniewski | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 23, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 23, 1971 8:50 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 3-01 | |
| 9. DATE OF BIRTH March 18, 1912 | | 10. AGE (In years last birthday) 58 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stanislaus Zaniewski | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman | |
| 15. MOTHER'S MAIDEN NAME Sophia Kosmaczewski | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. W. II | |
| 17. SOCIAL SECURITY NO. 218-10-7209 | | 18. INFORMANT ADDRESS Genevieve Kopacki - 6849 Duluth Ave. #21222 | |
| 19. 41214 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2/1/71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 24, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/21/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR George A. Weber | |
| 25C. FUNERAL DIRECTOR George A. Weber | | ADDRESS 705 S. Ann St. #21231 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0711 | |
|---|-------------------------|---|-------------------------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> S-634 71 0711 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Maria D. Sardella | | 1-18-71 | | 7:50 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1337 West 41st Street | | A. STATE Maryland | |
| | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 1337 West 41st Street, 21211 | | | |
| 5. SEX Fem. | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/12/15 | 9. AGE (In years lost birthday) 55 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed | | 10B. KIND OF BUSINESS OR INDUSTRY Travel Agency | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Marco DeLeonardis | | 14. MOTHER'S MAIDEN NAME Concetta Gallotta | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Guy Sardella - 1337 West 41st Street, 21211 | |
| 18. 154.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized carcinomatosis | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: Solus cerebrius vectorialis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Bilateral pleural effusion | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar. 20 19 70 to Jan. 18 19 71 , that (I) (we) last saw the deceased alive on Dec. 30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Roberto P. Prezioso | | | | 23B. DATE SIGNED 1-18-71 | |
| 23C. PHYSICIAN'S NAME (Type) Roberto P. Prezioso M.D. | | | | 23D. ADDRESS 1120 St Paul St. Balto 2, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/21/71 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | | |
| 25B. NAME OF REGISTRAR Joseph N. Zannino | | 25C. FUNERAL DIRECTOR ADDRESS Joseph N. Zannino, 263 S. Conkling St. | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0712

BIRTH NO.

REG. NO.

| | | | | | |
|---|--|--|--|--|------|
| 1. NAME OF DECEASED (Type or Print) ADAM KANIECKI (Kenny) | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 23, 1971 | | Month Day Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7 North Curly Curley St. 2-1-71 | | 3. DATE PRONOUNCED DEAD Month Day Year January 23, 1971 | | Hour 5:25 P M. | |
| 6. SEX Male | | 7. RACE White | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH July 28, 1901 | | 10. AGE (In years last birthday) 69 | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? 217-14-1868 | | 13. FATHER'S NAME Frank Kaniecki | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tugboat Fireman Retired | |
| 15. MOTHER'S MAIDEN NAME Joan - | | 16. INFORMANT Mrs. Fannie Kaniecki | | 17. SOCIAL SECURITY NO. 217-14-1868 | |
| 18. ADDRESS 7 North Curly Curley Street | | 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 22A. DATE OF OPERATION | | 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22C. AUTOPSY? (Yes or No) No | |
| 22D. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.) | | 22F. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22G. TIME (Month) (Day) (Year) (Hour) | | 22H. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22I. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Ronald E. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | January 24, 1971 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/27/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Ronald E. Kornblum, M.D. | |
| 25C. FUNERAL DIRECTOR Joseph N. Zannino - 263 S. Conklig ST. | | 25D. ADDRESS | | | |

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | |
| VIRGIE D. HINES | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (FULL NAME OF HOSPITAL OR INSTITUTION (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)) | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| Pier #4 Pratt St. | | Md. | | 1-05 | |
| 6. SEX | | 7. RACE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| female | | white | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years lost birthday) | | 11. BIRTHPLACE (State or foreign country) | |
| 6/13/46 | | 28 | | Cincinnati, Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| USA | | Andrew Jackson Goff | | waitress | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| Jeannette Goff | | No | | Mrs. Jeannette Goff - | |
| 18. INFORMANT | | 19. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Mrs. Jeannette Goff - | | Drowning | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | (D) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | |
| 2 | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| Pier #4 Pratt St. | | 1-15-71 | | Subj. drowned | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Isidore Mihalakis, M.D. | | Burial | | 1/20/71 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | |
| Baltimore | | Baltimore Md. | | JAN 25 1971 | |
| 25A. NAME OF REGISTRAR | | 25B. FUNERAL DIRECTOR | | 25C. ADDRESS | |
| Robert E. Jackson | | Joseph D. Zarembinski | | 1-7-71 | |

ACADEMY BOARD

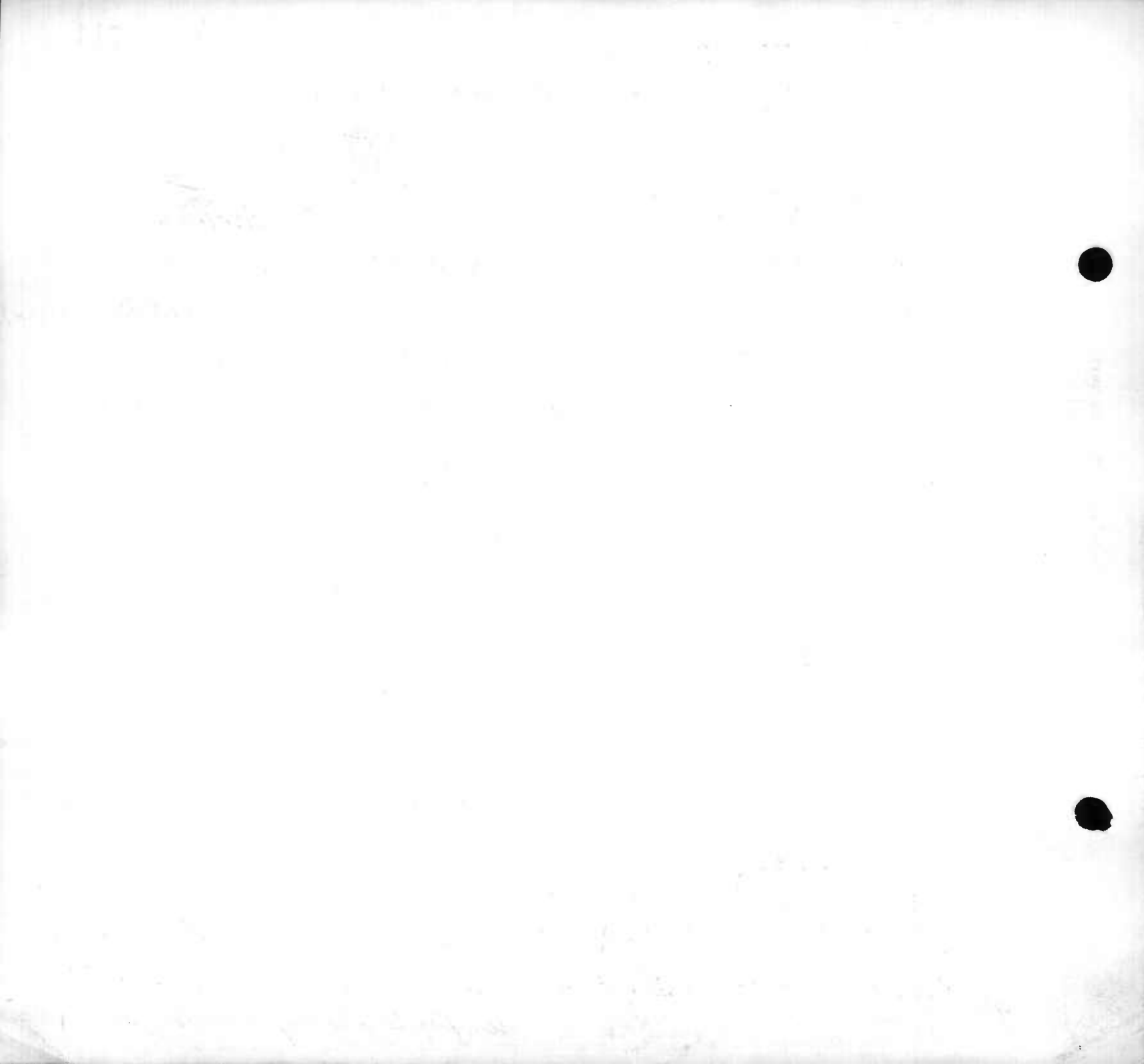
THE BOARD

VALLEY TAPER CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|--|---|---|---|--|--|
| W-526 71 0714 BIRTH NO. <u>Wenker Mrs Mary</u> | | | | | CERTIFICATE OF DEATH <u>X</u> REG. NO. <u>71 0714</u> | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Wenker, Mrs Mary L. (NEE SIENICKI)</u> | | | | | 2. DATE AND HOUR OF DEATH <u>11:45 AM 1-20-71</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>55 Church Home & Hospital</u> <u>Balt. MD 21231</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>DUNDALK</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7107 Martell Avenue 21222</u> | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>4-11-28</u> | 9. AGE (In years last birthday) <u>42</u> | If Under 1 Yr. Months: <u>—</u> Days: <u>—</u> | | If Under 24 Hrs. Hours: <u>—</u> Min: <u>—</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switchboard Operator</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN (usa)</u> | | |
| 13. FATHER'S NAME <u>John Siewicki</u> | | | 14. MOTHER'S MAIDEN NAME <u>Emelia Schneider</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>220 240607</u> | | 17. INFORMANT <u>Emelia Eder (Mother)</u> | | ADDRESS <u>7107 Martell Avenue</u> | | |
| 18. <u>287.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hepatic Coma.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cirrhosis of the Liver.</u> <u>Pernicious Anemia.</u> | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>3 days</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>3 month</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>3 months</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2/1</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-14 1970</u> to <u>1-20 1971</u> that (I) (we) last saw the deceased alive on <u>11-3AM 1-20 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>ROLANDO A. MENDOZA, M.D.</u> | | | | | 23B. DATE SIGNED <u>Jan. 20, 1971</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MENDOZA, M.D.</u> | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | | | | | 24B. DATE <u>1-23-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>CHRIST LUTHERAN CHURCH</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Dr. Frank Bradley, Dundalk, Md.</u> | | |
| 24D. LOCATION (City, town, or county) <u>21222</u> | | | | | 24E. LOCATION (City, town, or county) <u>GERMAN HILL Rd. BALD. Co. Md.</u> | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0715

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) AARON KNIGHT | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 21, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 21, 1971 8:50 A. M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 12-15-26 | | 10. AGE (In years lost birthday) 44 | |
| 11. BIRTHPLACE (State or foreign country) N. Carolina | | 12. CITIZEN OF U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME Gene Waseley | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korea War. | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Felix B. Knight | | ADDRESS 1701 Parker Ave. | |
| 19. CAUSE OF DEATH 425X | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Idopathic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) _____ DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) _____ | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21. AUTOPSY? (Yes or No) Yes | |
| ACTUAL SIGNATURE Charles S. Springate M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> January 21, 1971 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Removal | | 1-24-71 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Greenwood | | Tarboro N. Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| JAN 25 1971 | | Charles S. Springate | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| Elbert Funeral Home | | 1129 N. Carolina | |

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Funice Mason

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

521 E. 27th St.

6. SEX

female

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

M.

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

1

22

71

7:20 p

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

9-04

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1-22-97

10. AGE (In years last birthday)

74

Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

521 E. 27th St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Whittington

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Nancy Quinn

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

219-22-8738

18. INFORMANT

Ida. Ruyter

ADDRESS

same

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-27-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1971

25B. NAME OF REGISTRAR

R. N. Kornblum

25C. FUNERAL DIRECTOR

Ethel 50. Wilson

ADDRESS

1000 Pimlico

8150 17

UNITED STATES DEPARTMENT OF AGRICULTURE

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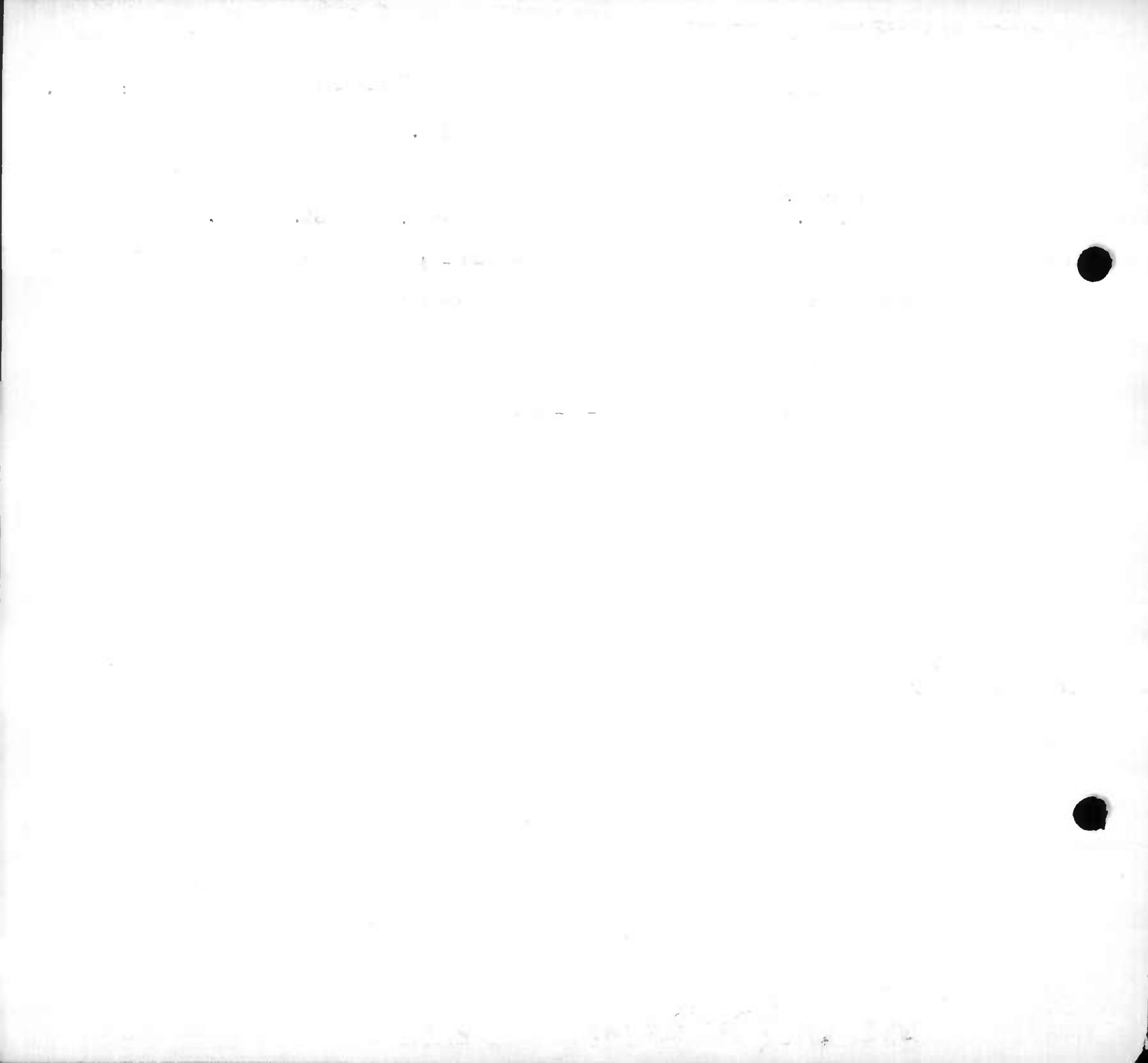
UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

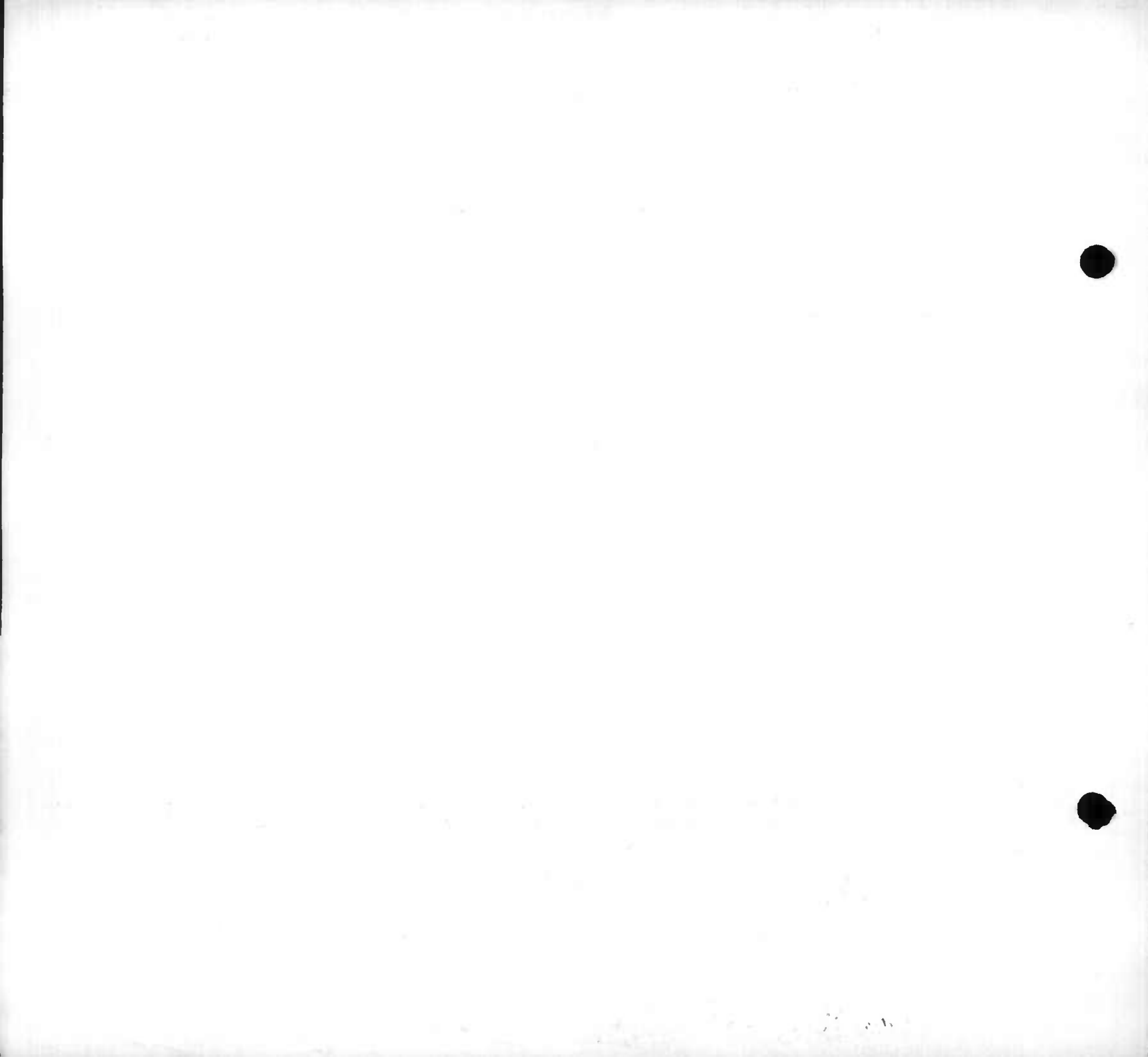
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0717 | |
|---|--|---|--|---|--|
| BIRTH NO. M-200 71 0717 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) M cCoy, Gladys | | 2. DATE AND HOUR OF DEATH 1-20-71 8:15 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto. B. COUNTY Maryland | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Hilton Nursing Home 3313 Poplar Street Baltimore, Md. | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F 6. RACE C | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-9-93 9. AGE (In years last birthday) 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Jessie Johnson | | 14. MOTHER'S MAIDEN NAME Harriett Gillman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-01-7461 | | 17. INFORMANT ADDRESS Batie Wilson Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of stomach | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-11-1970 to 11-20-1971 and that (I) (we) last saw the deceased alive on 1-8-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Barbu Calin | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1-20-71 | |
| 23C. PHYSICIAN'S NAME (Type) BARBU CALIN | | 23D. ADDRESS 831 Poplar Grove | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1-25-71 | | 24C. NAME of CEMETERY or CREMATORY McCormack Cent | |
| 24D. LOCATION (City, town, or county) (State) Ala County Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Rose E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Connelton 1000 Brantley Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0718 | |
|--|---|---|--|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Catherine Grayson | | 2. DATE AND HOUR OF DEATH 1-19-71 7:50 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. Sinai Nursing Home 4613 Park Heights Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 8-08 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1518 E. Chase St. | | | |
| 5. SEX F | 6. RACE Blk. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-1-90 | | 9. AGE (in years last birthday) 80 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 404X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Arteriosclerotic Cardio-Vascular (A) IMMEDIATE CAUSE Cerebral Disease DUE TO, OR AS A CONSEQUENCE OF: azotemia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1-19-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 8 1971 to January 19 1971 that (I) (we) last saw the deceased alive on January 19 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel Levin M.D. | | | | 23B. DATE SIGNED 1/19/71 | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D. | | | | 23D. ADDRESS 6101 PARK HTS AVE BALTO -15 MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-23-71 | | 24C. NAME of CEMETERY or CREMATORY Union | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS 1001 Broadway St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|--|--|---|
| J-530 71 0719 | | CERTIFICATE OF DEATH | | REG. NO. 71 0719 | |
| 1. NAME OF DECEASED (Type or Print) <u>TONDO Mr WILLIAM</u> | | | 2. DATE AND HOUR OF DEATH <u>1-22-71-5 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>M.D</u> B. COUNTY <u>1-01</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME AND HOSPITAL</u> <u>35 BALTIMORE. M.D-21231</u> | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>3037 Elliott St</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-14-15</u> | 9. AGE (In years last birthday) <u>55</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | |
| 13. FATHER'S NAME <u>ANTHONY TONDO</u> | | | 14. MOTHER'S MAIDEN NAME <u>G. GRACE</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>217-01-4549</u> | | 17. INFORMANT <u>Dorothy Tondo. 3037 Elliott St</u> |
| 18. <u>157.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Extensive metastasis of Carcinoma of Pancreas</u> | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Extensive metastasis of Carcinoma of Pancreas</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>11-2-70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>On Pancreas</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examiner's opinion) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) Month Day Year Hour | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-16-71</u> 19 to <u>1-22-71</u> 19 that (I) (we) last saw the deceased alive on <u>1-22-71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>T. Sree Ramamurthy</u> | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) <u>T. SREE RAMAMURTHY</u> | | | 23D. ADDRESS <u>Church Home and Hospital. M.D-21231</u> | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-26-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Bellair Memorial</u> | |
| 24D. LOCATION <u>Bellair</u> | | 24E. CITY, TOWN, OR COUNTY <u>Md.</u> | | 24F. STATE <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>Philip E. Salsbery</u> | | 25C. FUNERAL DIRECTOR <u>Shirley A. Hoffman</u> | |
| 25D. ADDRESS <u>3218 Hudson St</u> | | | | | |

K 520

71 0720

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0720

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

Louis King (Louis D. Jones)

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

5:10 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
(If institution)(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secours Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

5:10 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

CERTIFICATE AMENDED

6. SEX

male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Feb. 22, 1938

10. AGE (In years
lost birthday)

32 35-9

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1317 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

James F. Smithson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosemary King

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W W 2

17. SOCIAL
SECURITY NO.

212-31-9914

18. INFORMANT

M's King, same

ADDRESS

19.

345.9 1 + 2887X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Acute & Chronic subdural hematoma

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Epileptic seizure

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Cirrhosis of liver

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☒ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? Was found unconscious on side-

walk in unit blk. of N. Woodyear Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

1-14-71

Unk. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Deceased apparently had epileptic seizure
and fell

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/15/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/26/71

24C. NAME of CEMETERY or CREMATORY

MT Calvary Cemetery

24D. LOCATION (City, town, or county)

A A County Md

(Site)

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1971

25B. NAME OF REGISTRAR

R. E. Jones, Jr.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

1/27/71 - Birth certificate - E-75885. Date of birth: Feb. 22, 1938.

Letter from M.E.'s office

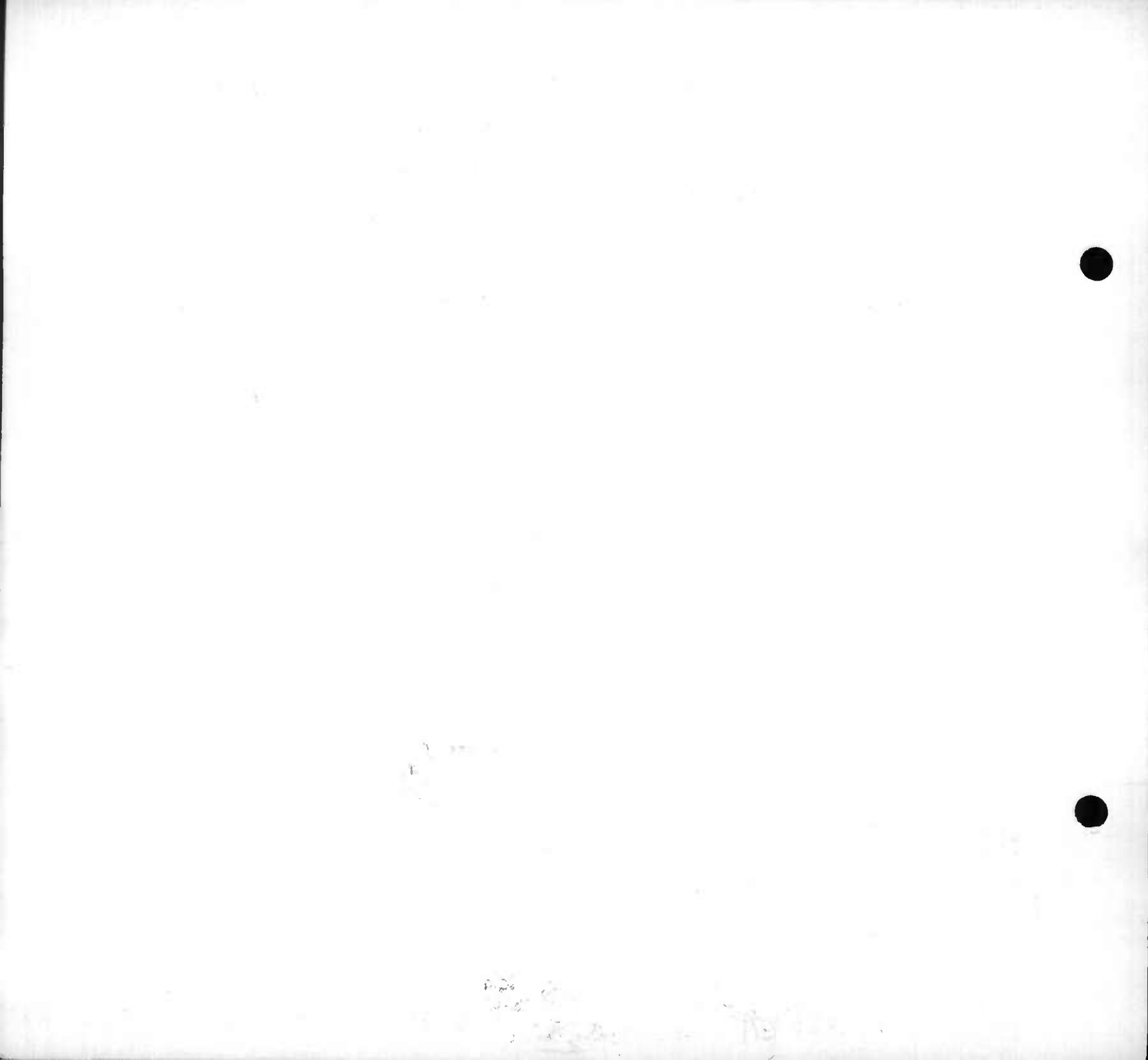
3-26-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0721</u> |
|---|--|--|--|---|
| BIRTH NO. <u>71 0721</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>MILLIE TAYLOR PITMAN</u> | | 2. DATE AND HOUR OF DEATH <u>JANUARY 22, 1971</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-03</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>541 N Fulton Ave</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>F</u> | | 6. RACE <u>C</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) <u>70</u> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | 13. FATHER'S NAME <u>?</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>?</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs Lelia Jackson, same</u> ADDRESS | | |
| 18. <u>102X</u> I | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>remittent</u> DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) <u>hypertension</u> | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19 65</u> to <u>1-22-1971</u> that (I) (we) last saw the deceased alive on <u>1-22-</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. DATE SIGNED <u>1-23-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>TURGET JUDY. MD</u> |
| 23D. ADDRESS <u>549 N. FULTON AVE, BALD. MD, 21225</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>1/26/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>MT Calvary Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>A A County M</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>1206 W North Ave</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 501 St Marys St | | 71 0722 | |
|---|-----------------------|---|--|--|--|--|--|
| BIRTH NO. 71 0722 | | | | CERTIFICATE OF DEATH | | Registered No. 71 0722 | |
| 1. NAME OF DECEASED (Type or Print) JOHN TILLEY | | | | 2. DATE AND HOUR OF DEATH 1-15-71 6:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY 17-01 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 501 MARY ST 21201 | | | |
| 5. SEX M | 6. RACE W C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 1-1-1894 | | 9. AGE (In years last birthday) 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GEORGIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN TILLEY | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 260-05-1290 | | 17. INFORMANT MARY LEE McGUIRT | | ADDRESS SAME | |
| 18. 269.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) MASSIVE GASTRO-INTESTINAL BLEEDING DUE TO SEVERE MALNUTRITION & CIRRHOSIS & HEPATOMA | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-15 1971 to 1-15 1971 , that (I) (we) lost saw the deceased alive on 1-15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Whitney Naughton | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-19-71 | |
| 23C. PHYSICIAN'S NAME (Type) W. HAUGHTON | | M.D. | | 23D. ADDRESS Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-26-71 | | 24C. NAME of CEMETERY or CREMATORY MT. CARMEL | | 24D. LOCATION (City, town, or county) (State) BALTO MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR W. E. Taylor, MD. | | 25C. FUNERAL DIRECTOR MARY ELIZABETH LAUI | | ADDRESS -802 MADISON AVE | |

561 Lt. Mary Lt.

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A 536

71 0723

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0723
REG. NO.

| | | | | | |
|--|------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) JAMES L. ANDERSON | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 20 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2614 Spring Hill Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 20 1970 11:20a M. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-12 | |
| 6. SEX male | 7. RACE negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1910 Jan. 5, 1910 | | 10. AGE (In years last birthday) 61 | 11. BIRTHPLACE (State or foreign country) Sumter, S. C. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Frank Anderson | | E. STREET AND NUMBER 2614 Spring Hill Ave. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Amelia ? | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 218-05-7072 | | 18. INFORMANT Mrs. Sallie Anderson 2614 Springhill Ave. | |
| 19. 3-71.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-20-71 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-23-71 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Mary-Elizabeth Law | | 25C. FUNERAL DIRECTOR ADDRESS 802 Madison Avenue | |

ACADEMY ROAD

WIDE STREET

WIDE STREET

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M. 460

71 0724

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0724
REG. NO.

| | | | | | |
|--|-------------------------|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) T. Booker Miller | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 17 71 9:30 p. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 71 9:30 p. M. | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 16-05 | |
| 6. SEX male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH Sept. 7, 1913 | | 10. AGE (In years last birthday) 57 | | E. STREET AND NUMBER 2300 Lauretta | |
| 11. BIRTHPLACE (State or foreign country) Jefferson, S. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Edgar Miller | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY 248-32-8828x | | 15. MOTHER'S MAIDEN NAME Bertha Horton | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 248-32-8828 | | 18. INFORMANT ADDRESS Helen Couser - 2300 Lauretta Ave. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E966X | | CAUSE OF DEATH Multiple stab wounds of chest and abdomen | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 900 Blk. N. Payson St. 16-04 | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1 17 71 8:30 p. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/18/71 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-24-71 | | 24C. NAME of CEMETERY or CREMATORY Hopewell Church Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Jefferson, S. C. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR Mary-Elizabeth Law | | 25D. ADDRESS 802 Madison Ave. | | | |

1950

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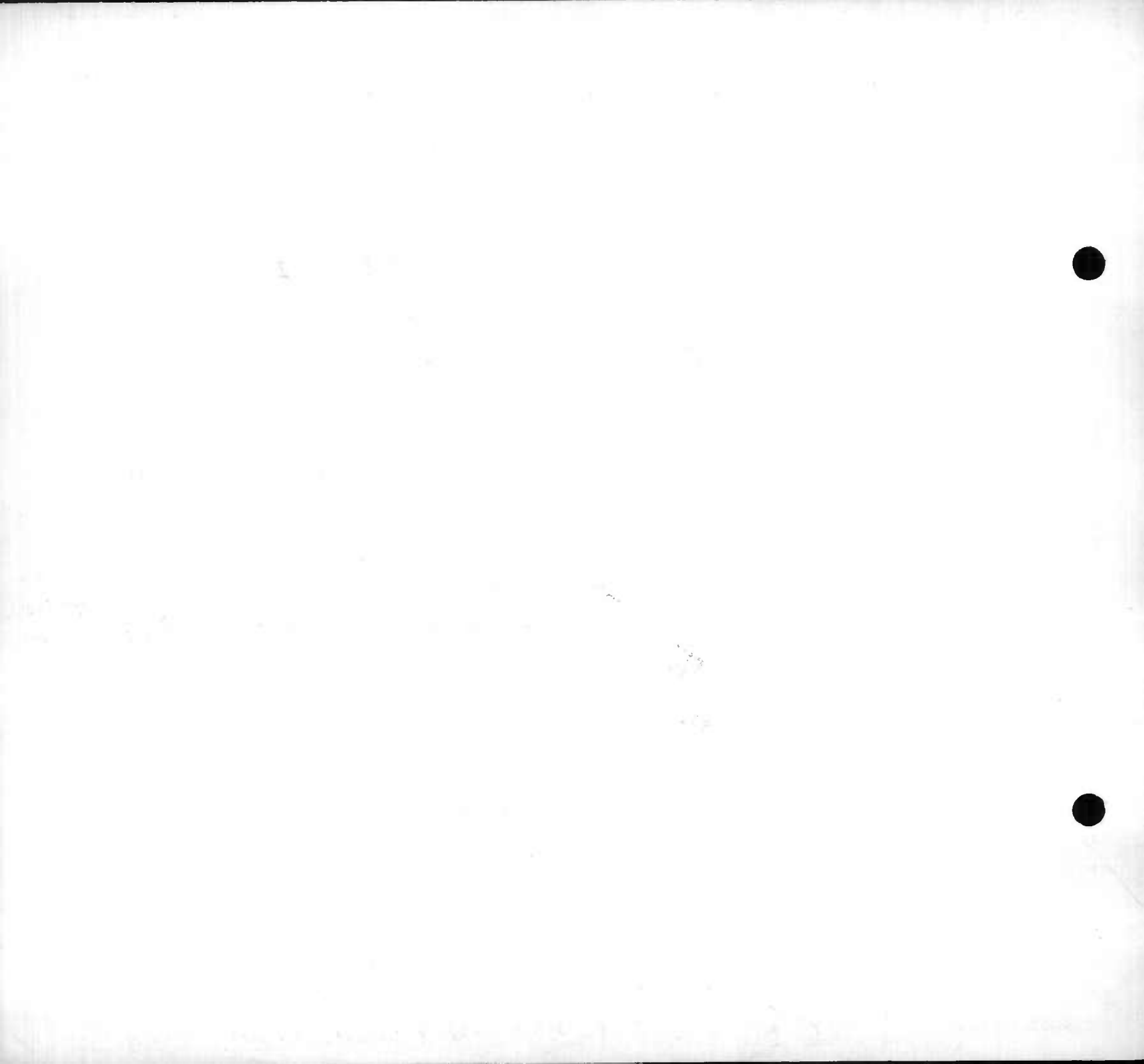
1950

ACADEMIC RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

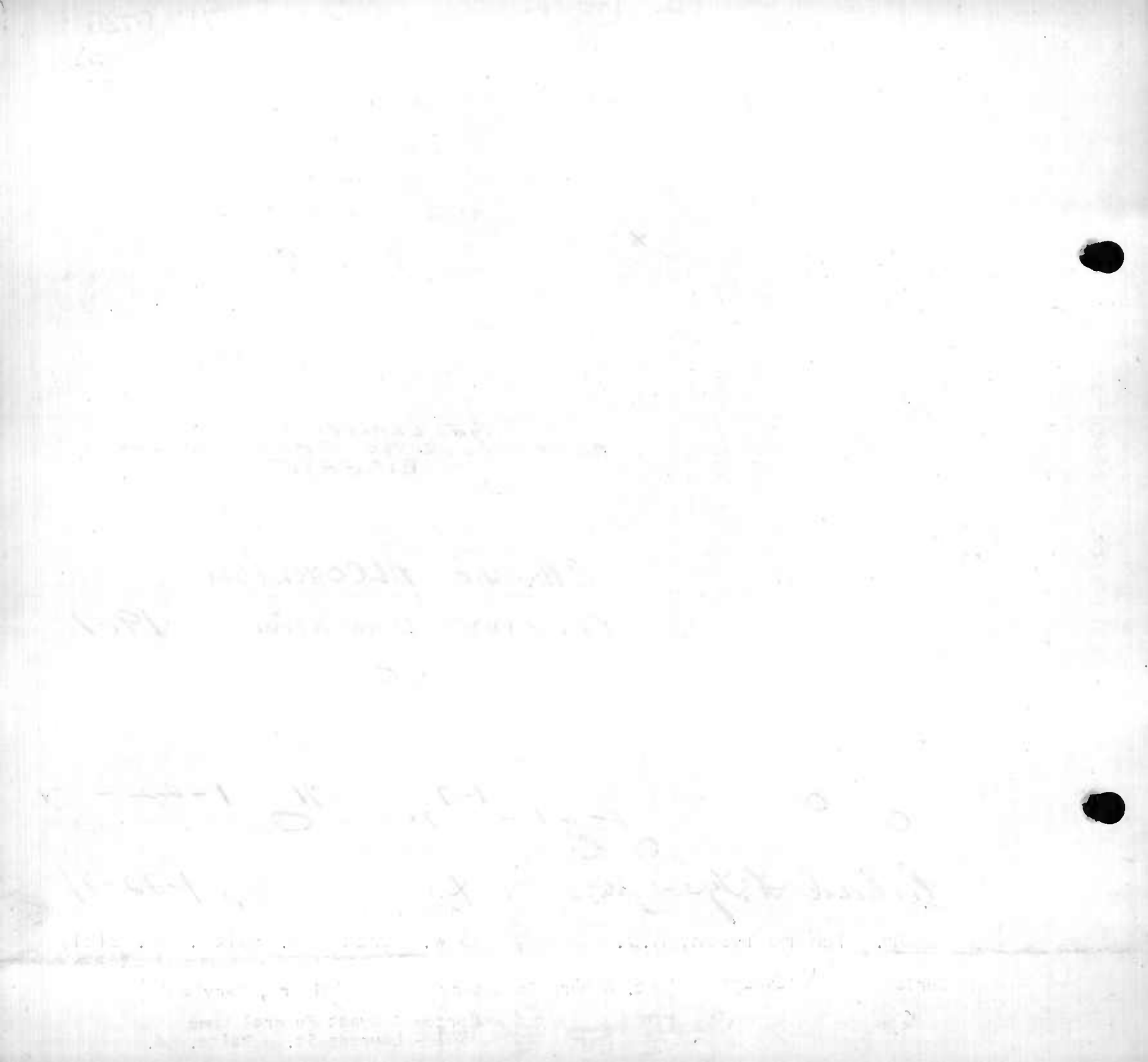
| 71 0725 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0725 | |
|---|-----------------------------|--|------------------------------------|---|---|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED Type or Print MAYLON RICHARD FINNEY | | 2. DATE AND HOUR OF DEATH Jan 23, 1971 4¹⁰ AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Univ. of Md. Hospital | | A. STATE Md | | B. COUNTY 25-53 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Balto | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 2206 Serern St. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 3-18-08 | 9. AGE (In years last birthday) 62 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 13. FATHER'S NAME RICHARD FINNEY | | 14. MOTHER'S MAIDEN NAME Mary Moore | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216-18-4844 | | 17. INFORMANT ADDRESS HOSP. RECORD | |
| 18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrests, multiple 12hrs. (B) pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic alcoholism pneumonia Chronic alcoholism | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks? 50 years 2 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1-22-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-22-71 to 1-23-71 that (I) (we) last saw the deceased alive on 1-21-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Federick Pearson M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-23-71 | |
| 23C. PHYSICIAN'S NAME (Type) FREDERICK PEARSON M.D. | | 23D. ADDRESS Univ. of Md. Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 1-26-71 | 24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS MARY-ELIZABETH LAW - 802 MADISON AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

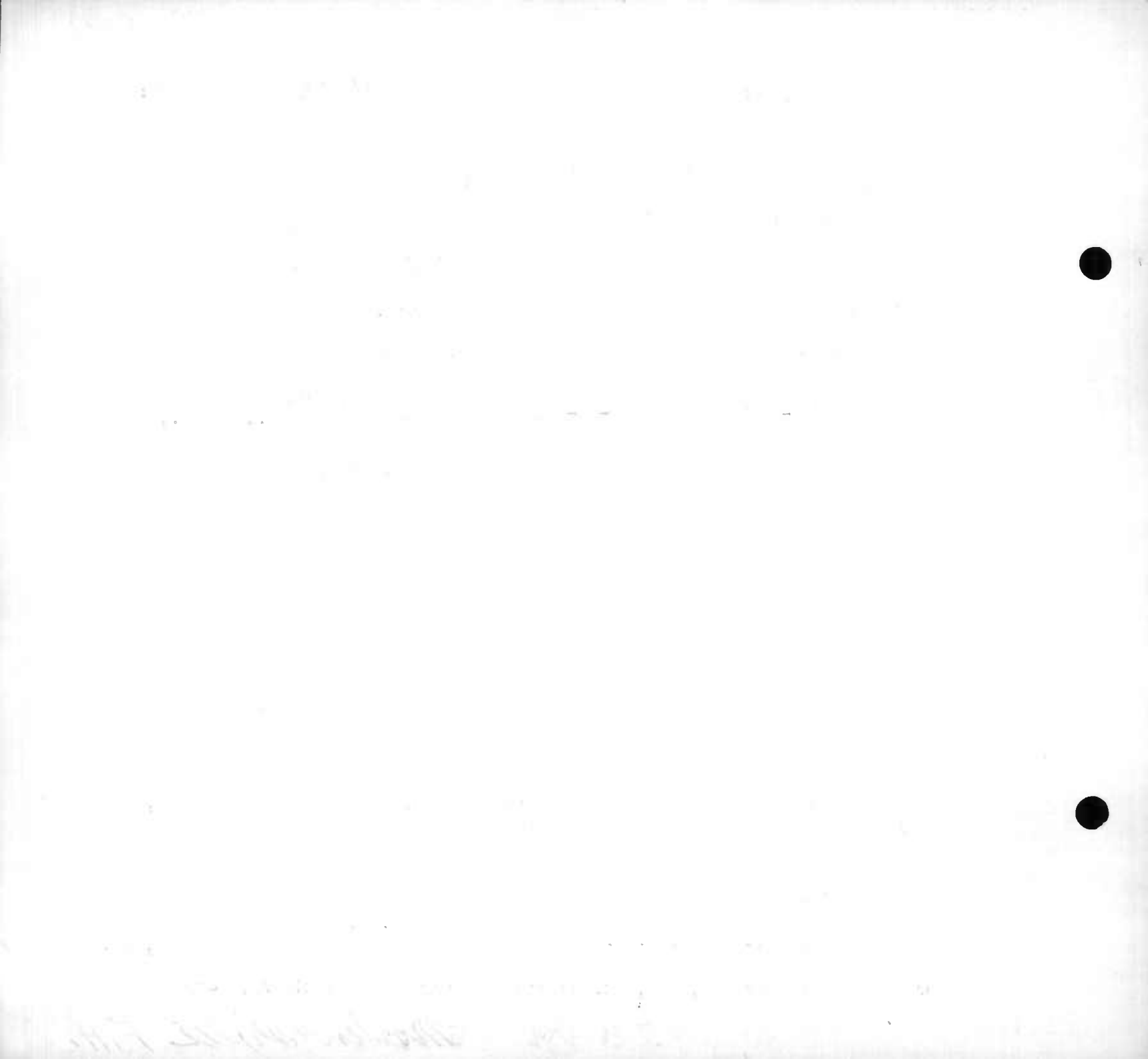
| | | | |
|--|-------------------------|---|------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0726 | |
| BIRTH NO. 71 0726 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) James Butler | | 2. DATE AND HOUR OF DEATH 1/22/71 4:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission) A. STATE Maryland B. COUNTY 15-42 | |
| FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home 607 Pennsylvania Ave. | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 3102 Clifton Ave. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/19/98 |
| 9. AGE (In years lost birthday) 72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Butler | | 14. MOTHER'S MAIDEN NAME Katie Butler | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 217-05-8128A | |
| 17. INFORMANT CHART | | ADDRESS 607 Pennsylvania Ave. | |
| 18. 412.4 & 303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GENERALIZED ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC ALCOHOLISM | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHLORINE INTALATION | | 1961 | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 1-7 19 71 to 1-22 19 71 , that (2) (we) last saw the deceased alive on 1-21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Richard A. Tyson, M.D. | | 23B. DATE SIGNED 1-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Richard Tyson, M.D. | | 23D. ADDRESS 936 W. North Ave. Balto. Md. 21217 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR John E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR Morton & Pyatt Funeral Home | | ADDRESS 1701 1/2 Laurens St. Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

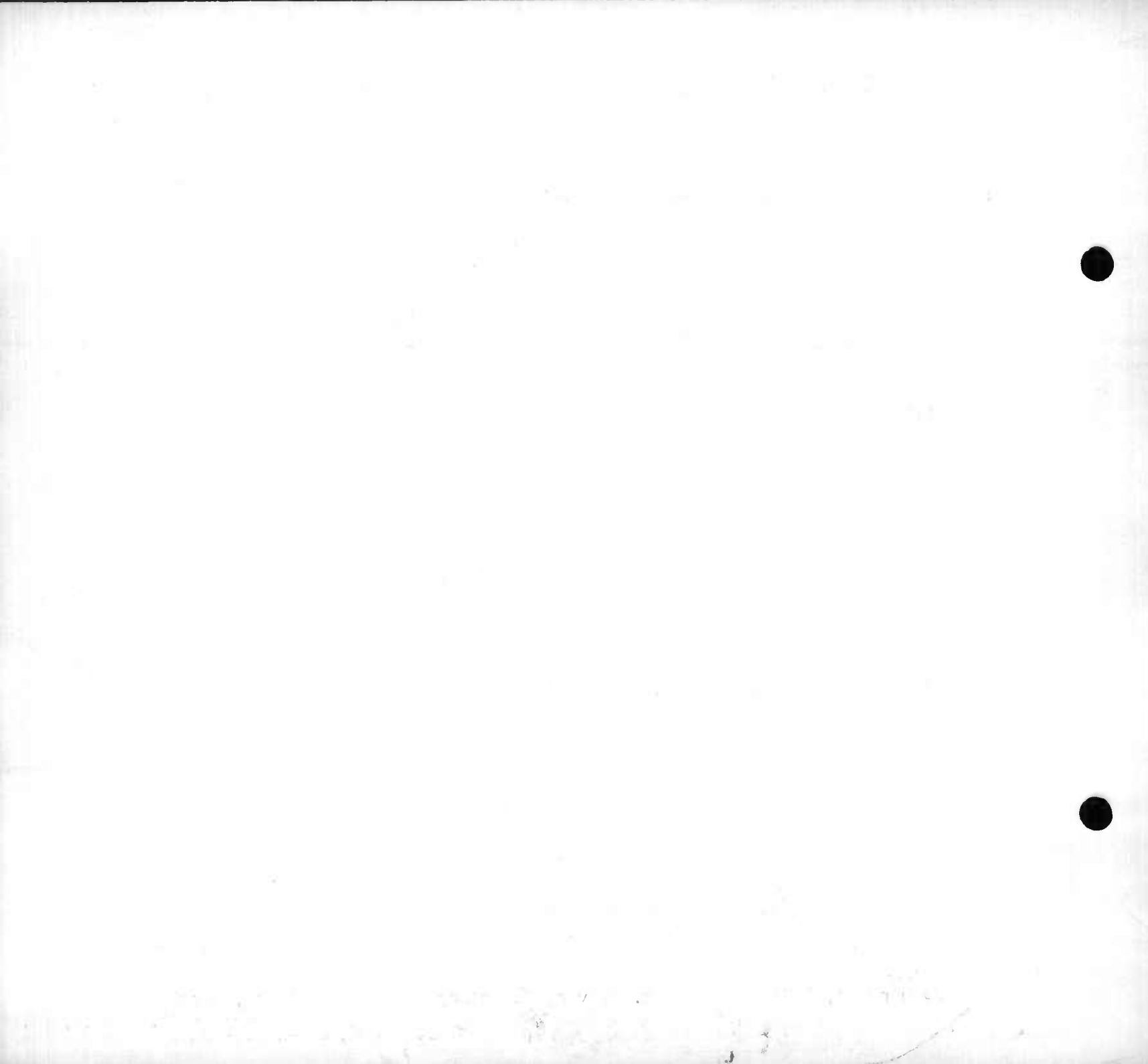
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0727 | |
|--|--|---|--|---|--|
| BIRTH NO. 71 0727 | | BALTIMORE CITY HEALTH DEPARTMENT | | | |
| 1. NAME OF DECEASED (Type or Print) JOHNSON, Bernard | | 2. DATE AND HOUR OF DEATH 1/21/71 12:25 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 19-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/18/33 9. AGE (in years last birthday) 37 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | |
| 13. FATHER'S NAME Earl Johnson | | 14. MOTHER'S MAIDEN NAME Helen Rodgers | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1952 - 1955 | | 16. SOCIAL SECURITY NO. 213-30-4772 | | 17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md | |
| 18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) HEPATORENAL FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatorenal failure (B) ALCOHOLIC HEPATITIS DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months 2 Months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from December 20, 1970 to January 21, 1971 that (X) (we) last saw the deceased alive on January 21, 1971 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kameel F. Farag, M.D. | | 23B. DATE SIGNED 1-21-71 | | 23C. PHYSICIAN'S NAME (Type) Kameel F. Farag, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE January 26, 1971 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. | | 24F. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Farag, M.D. | | 25C. FUNERAL DIRECTOR Mortimer + Lyette F.H. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0728 | |
|--|--|---|---|---|---|
| BIRTH NO. 71 0728 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ELIJAH ACEY JORDAN | | | 2. DATE AND HOUR OF DEATH JANUARY 22, 1971 345 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Univ of Md. Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21217 | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Univ of Md. Hospital | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 6. SEX M 7. RACE N 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. DATE OF BIRTH 6-5-24 10. AGE (in years last birthday) 46 | | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 12. BIRTHPLACE (State or foreign country) Virginia | | |
| 13. FATHER'S NAME ACEY JORDAN | | | 14. MOTHER'S MAIDEN NAME Estelle Tucker | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Univ of Md. Hospital chart |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 486 X I | | | CAUSE OF DEATH Cardiac arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypoxia | | 11 |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: pneumonia | | 1 week |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | Shock, status epilepticus | | 2 days |
| 19A. DATE OF OPERATION 1/21 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (S) chest tube (pneumothorax) | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-20-71 19 71 to 1-22 19 71 that (I) (we) last saw the deceased alive on 1-22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Frederick Pearson, M.D. | | | | 23B. DATE SIGNED 1-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) FREDERICK PEARSON, M.D. | | | | 23D. ADDRESS Univ of Md. Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE January 27, 1971 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, Jr. | | 25C. FUNERAL DIRECTOR 1701 Laurens St., Baltimore, Md. | | | |
| 25D. ADDRESS Morton & Dyett Funeral Home | | | | | |



M. 220

71 0729

BALTIMORE CITY HEALTH DEPARTMENT

71 0729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| BERTHA MACIOCH | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | January 23, 1971 | | January 23, 1971 | | A. STATE Maryland B. COUNTY Baltimore | |
| 6. SEX Female | | 7. RACE White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. DATE OF BIRTH 9-4-88 | | 10. AGE (In years last birthday) 82 | |
| 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? Poland | | 13. FATHER'S NAME John Dec | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 15. MOTHER'S MAIDEN NAME Mary Phillips | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 215-63-48948 | | 18. INFORMANT Mrs. Genevieve Bloom | | 19. CAUSE OF DEATH | | 20. DATE OF OPERATION | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Arteriosclerotic cardiovascular disease | | 21. AUTOPSY? (Yes or No) No | | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 23. TIME OF INJURY (APPROX.) | |
| 20. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 24. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | | 25. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 26. NAME OF REGISTRAR | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 27. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 28. DATE 1/27/71 | | 29. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 22. ANTECEDENT CAUSES | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | 30. DATE 1/27/71 | | 31. NAME OF REGISTRAR | | 32. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 24. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 33. DATE 1/27/71 | | 34. NAME OF REGISTRAR | | 35. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 24. DATE OF OPERATION | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 36. DATE 1/27/71 | | 37. NAME OF REGISTRAR | | 38. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 25. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH. | | 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 39. DATE 1/27/71 | | 40. NAME OF REGISTRAR | | 41. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 26. TIME (Month) (Day) (Year) (Hour) | | 27. HOW DID INJURY OCCUR? | | 42. DATE 1/27/71 | | 43. NAME OF REGISTRAR | | 44. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 28. CHIEF MEDICAL EXAMINER | | 45. DATE 1/27/71 | | 46. NAME OF REGISTRAR | | 47. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 29. ACTUAL EXAMINER'S NAME (Type) Ronald E. Kornblum, M.D. | | 30. ASSISTANT MEDICAL EXAMINER | | 48. DATE 1/27/71 | | 49. NAME OF REGISTRAR | | 50. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 31. DATE 1/27/71 | | 32. NAME OF REGISTRAR | | 51. DATE 1/27/71 | | 52. NAME OF REGISTRAR | | 53. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 33. DATE 1/27/71 | | 34. NAME OF REGISTRAR | | 54. DATE 1/27/71 | | 55. NAME OF REGISTRAR | | 56. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 35. DATE 1/27/71 | | 36. NAME OF REGISTRAR | | 57. DATE 1/27/71 | | 58. NAME OF REGISTRAR | | 59. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 37. DATE 1/27/71 | | 38. NAME OF REGISTRAR | | 60. DATE 1/27/71 | | 61. NAME OF REGISTRAR | | 62. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 39. DATE 1/27/71 | | 40. NAME OF REGISTRAR | | 63. DATE 1/27/71 | | 64. NAME OF REGISTRAR | | 65. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 41. DATE 1/27/71 | | 42. NAME OF REGISTRAR | | 66. DATE 1/27/71 | | 67. NAME OF REGISTRAR | | 68. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 43. DATE 1/27/71 | | 44. NAME OF REGISTRAR | | 69. DATE 1/27/71 | | 70. NAME OF REGISTRAR | | 71. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 45. DATE 1/27/71 | | 46. NAME OF REGISTRAR | | 72. DATE 1/27/71 | | 73. NAME OF REGISTRAR | | 74. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 47. DATE 1/27/71 | | 48. NAME OF REGISTRAR | | 75. DATE 1/27/71 | | 76. NAME OF REGISTRAR | | 77. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 49. DATE 1/27/71 | | 50. NAME OF REGISTRAR | | 78. DATE 1/27/71 | | 79. NAME OF REGISTRAR | | 80. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 51. DATE 1/27/71 | | 52. NAME OF REGISTRAR | | 79. DATE 1/27/71 | | 80. NAME OF REGISTRAR | | 81. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 53. DATE 1/27/71 | | 54. NAME OF REGISTRAR | | 80. DATE 1/27/71 | | 81. NAME OF REGISTRAR | | 82. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 55. DATE 1/27/71 | | 56. NAME OF REGISTRAR | | 81. DATE 1/27/71 | | 82. NAME OF REGISTRAR | | 83. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 57. DATE 1/27/71 | | 58. NAME OF REGISTRAR | | 82. DATE 1/27/71 | | 83. NAME OF REGISTRAR | | 84. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 59. DATE 1/27/71 | | 60. NAME OF REGISTRAR | | 83. DATE 1/27/71 | | 84. NAME OF REGISTRAR | | 85. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 61. DATE 1/27/71 | | 62. NAME OF REGISTRAR | | 84. DATE 1/27/71 | | 85. NAME OF REGISTRAR | | 86. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 63. DATE 1/27/71 | | 64. NAME OF REGISTRAR | | 85. DATE 1/27/71 | | 86. NAME OF REGISTRAR | | 87. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 65. DATE 1/27/71 | | 66. NAME OF REGISTRAR | | 86. DATE 1/27/71 | | 87. NAME OF REGISTRAR | | 88. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 67. DATE 1/27/71 | | 68. NAME OF REGISTRAR | | 87. DATE 1/27/71 | | 88. NAME OF REGISTRAR | | 89. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 69. DATE 1/27/71 | | 70. NAME OF REGISTRAR | | 88. DATE 1/27/71 | | 89. NAME OF REGISTRAR | | 90. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 71. DATE 1/27/71 | | 72. NAME OF REGISTRAR | | 89. DATE 1/27/71 | | 90. NAME OF REGISTRAR | | 91. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 73. DATE 1/27/71 | | 74. NAME OF REGISTRAR | | 90. DATE 1/27/71 | | 91. NAME OF REGISTRAR | | 92. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 75. DATE 1/27/71 | | 76. NAME OF REGISTRAR | | 91. DATE 1/27/71 | | 92. NAME OF REGISTRAR | | 93. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 77. DATE 1/27/71 | | 78. NAME OF REGISTRAR | | 92. DATE 1/27/71 | | 93. NAME OF REGISTRAR | | 94. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 79. DATE 1/27/71 | | 80. NAME OF REGISTRAR | | 93. DATE 1/27/71 | | 94. NAME OF REGISTRAR | | 95. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 81. DATE 1/27/71 | | 82. NAME OF REGISTRAR | | 94. DATE 1/27/71 | | 95. NAME OF REGISTRAR | | 96. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 83. DATE 1/27/71 | | 84. NAME OF REGISTRAR | | 95. DATE 1/27/71 | | 96. NAME OF REGISTRAR | | 97. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 85. DATE 1/27/71 | | 86. NAME OF REGISTRAR | | 96. DATE 1/27/71 | | 97. NAME OF REGISTRAR | | 98. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 87. DATE 1/27/71 | | 88. NAME OF REGISTRAR | | 97. DATE 1/27/71 | | 98. NAME OF REGISTRAR | | 99. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |
| 89. DATE 1/27/71 | | 90. NAME OF REGISTRAR | | 98. DATE 1/27/71 | | 99. NAME OF REGISTRAR | | 100. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | |

11 0750

11 0750

UNITED STATES DEPARTMENT OF STATE

John Dec
Mary Philip

9-4-77

FOR THE SECRETARY OF STATE

TO THE SECRETARY OF STATE

OFFICE OF THE SECRETARY OF STATE

...

71 0730

BALTIMORE CITY HEALTH DEPARTMENT

71 0730

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) RAYMOND PERTICONE | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3008 1/2 Hamilton Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 23, 1971 3:15 P M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH August 14, 1910 | | 10. AGE (In years lost birthday) 60 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Angelo Perticone | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-44 | |
| 15. MOTHER'S MAIDEN NAME Josephine Perticone | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ? | |
| 17. SOCIAL SECURITY NO. 220-07-4107 | | 18. INFORMANT ADDRESS Joseph Perticone 912 Dartmouth Rd. | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Bethlehem Steel Corp. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 22. (C) _____ | | 23. _____ | |
| 20A. DATE OF OPERATION 1/26/71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) No | | 22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. _____ | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Ronald E. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED January 24, 1971 | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Ronald E. Kornblum, M.D. | |
| 25C. FUNERAL DIRECTOR ADDRESS Chas. L. Stevens Funeral Home, Inc., 6725 East Fort Avenue | | 25D. _____ | |

VI 0730

VI 0730

RECORD OF C. L. BARKER - 1917

RECORD OF C. L. BARKER - 1917

RECORD OF C. L. BARKER - 1917

RECORD OF C. L. BARKER - 1917

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RECORD OF C. L. BARKER - 1917

RECORD OF C. L. BARKER - 1917

RECORD OF C. L. BARKER - 1917

L-000

71 0731

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0731

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Schoeler</i> <i>William A Loewe</i> | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 22 71 8:05 p M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION <i>2226 Frederick Ave.</i> | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 22 71 8:05 p M. | |
| 6. SEX <i>male</i> | | 7. RACE <i>white</i> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>20-04</i> | |
| 9. DATE OF BIRTH <i>Feb. 3, 1909</i> | | 10. AGE (In years last birthday) <i>61</i> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i> | | 14B. KIND OF BUSINESS OR INDUSTRY <i>Johns Hopkins Univ</i> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 17. SOCIAL SECURITY NO. <i>218-36-3364</i> | |
| 18. INFORMANT <i>William Gessage</i> | | ADDRESS <i>1201 Gregory Ave Balto, Md. 21207</i> | |
| 19. CAUSE OF DEATH <i>571181</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (A) IMMEDIATE CAUSE <i>Fatty Metamorphosis of Liver</i> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION <i>2</i> | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) <i>Ronald N. Kornblum, M.D.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>1/23/71</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/26/71</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>London Park Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. J. [illegible]</i> | |
| 25C. FUNERAL DIRECTOR <i>George L. Schwab, Inc.</i> | | ADDRESS <i>2101 Fred Ave Balto, Md.</i> | |

H-400

71

0732

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

0732

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Raymond W. Hall

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

1

23

71

12:20 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

6-04

6. SEX

male

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

April 26

10. AGE (In years
last birthday)

16

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

214 N. Chester St.

11. BIRTHPLACE (State or foreign country)

Baltimore md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Carl Williams

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sophie Williams

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Sybil Williams

ADDRESS

19. E 814.7

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Orleans and Chester Sts.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

1

22

71

10:15p m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

pedestrian struck by panel truck

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1- - 71

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

md

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1971

25B. NAME OF REGISTRAR

Robert E. J. Taylor

25C. FUNERAL DIRECTOR

B. D. Wilson, 1000 Brantly St.

ADDRESS

17

17

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. [REDACTED] | |
|--|---------|--|---|---|---|
| Z-460 71 0733 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ANDREW ZELLER | | 1-22-71 4:45 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 44 Union Memorial Hospital | | | Maryland 9-12 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 1615 Balworth Rd | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 3-14-96 | 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| RETIRED-TELLER | | | FIRST NATIONAL BANK | | Maryland |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Andrew Zeller | | | Mary C. Benzel | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | 217-14-1968 | | MRS. AUDREY S. ZELLER (SAME) |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | | B. BROCHOPNEUMONIA (inoperable) | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-15-1971 to 1-22-1971 that (I) (we) last saw the deceased alive on 1-22-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| In Kapiza H. D. DEGREE | | | | 1-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| HARIELY NAPIZA | | | | Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1/25/71 | | Woodlawn | |
| | | | | Baltimore County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 25 1971 | | Robert J. Jenkins | | H. O. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| B-550 71 0734 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REC. NO. 71 0734 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) HARRY F. BAUMANN | | 2. DATE AND HOUR OF DEATH JAN 22 1971 11 15 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) North Charles Gen. Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 12-01 | | C. CITY OR TOWN Baltimore | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 3/6/84 | | 9. AGE (In years last birthday) 86 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - TRUST DEPT. | | 10B. KIND OF BUSINESS OR INDUSTRY MERCANTILE SAFE DEPOSIT | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Joseph Baumann | | 14. MOTHER'S MAIDEN NAME Rosa | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-03-1963 | | 17. INFORMANT J. Papadimitrakou, N. Charles Hoff. | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coriatic Arrest | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) ASCVD | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from January 20 1971 to JAN 22 1971 that (I) (we) last saw the deceased alive on January 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Anthony C. Papadimitrakou, M.D. | | 23B. DATE SIGNED 1/22/71 | | 23C. PHYSICIAN'S NAME (Type) A. C. PAPADIMITRAKOU, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Entombment | | 24B. DATE 1/25/71 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park Mausoleum | |
| 24D. LOCATION (City, town, or county) (State) Baltimore County, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | |
| 25C. FUNERAL DIRECTOR H. O. Jenkins & Sons Co. | | 25D. ADDRESS 4905 York Rd. Balto., Md. 21212 | | | |

V.S. 153

2-3-71

M.H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) RALPH JACKSON | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 20, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Ben Secours Hospital (If not in hospital or institution, give street address or location) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 20, 1971 7:45 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH SEPT. 17, 1891 | | 10. AGE (in years lost birthday) 79 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) PENNA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. G.D.V. | | 14B. KIND OF BUSINESS OR INDUSTRY MARITIME COMM. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 213-24-3354 | |
| 15. MOTHER'S MAIDEN NAME UNK | | 18. INFORMANT ARMENDEL JACKSON - WIFE - SAME | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED January 21, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1-23-71 | |
| 24C. NAME OF CEMETERY or CREMATORY GREENMOUNT | | 24D. LOCATION (City, town, or county) (State) BALTO. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR W. D. Kelly, Registrar, M.D. | |
| 25C. FUNERAL DIRECTOR W. D. Kelly, Registrar, M.D. | | ADDRESS | |

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0736 | | | |
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| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 71 0736 | | | |
| BIRTH NO. <u>ALLEN</u> | | | | REG. NO. <u>71 0736</u> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>LOUISE JAMES</u> | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <u>January 23, 1971</u> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital (DOA)</u> | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour <u>January 23, 1971 5:15 P. M.</u> | | | |
| 6. SEX <u>Female</u> 7. RACE <u>White</u> B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTIMORE</u> | | | |
| 9. DATE OF BIRTH <u>MAY 27, 1900</u> 10. AGE (In years (last birthday)) <u>70</u> 11 Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min. | | | | C. CITY OR TOWN <u>DUNDALK Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | E. STREET AND NUMBER <u>44 York Way</u> | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 14B. KIND OF BUSINESS OR INDUSTRY | | | | 13. FATHER'S NAME <u>PATRICK ALLEN</u> | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 15. MOTHER'S MAIDEN NAME <u>U.N.K.</u> | | | |
| 17. SOCIAL SECURITY NO. <u>213-48-6327</u> | | | | 18. INFORMANT ADDRESS <u>W. A. JAMES (SON) 7807 HAROLD RD. 21222</u> | | | |
| 19. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION <u>2/27</u> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) <u>Yes</u> | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>January 24, 1971</u> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-27-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Ronald N. Kornblum</u> | | 25C. FUNERAL DIRECTOR <u>W. A. James</u> | | ADDRESS <u>7807 Harold Rd.</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 71 0737 | | | | | 71 0737 | | | | | |
| BIRTH NO. 71 0737 | | | | | 1. NAME OF DECEASED (Type or Print) William D. Goldberg | | | | | |
| 2. DATE AND HOUR OF DEATH Jan. 21, 1971 8:15 A.M. | | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE, INC | | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| E. STREET AND NUMBER 3321 Shelburne Road. | | | | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH XXXXX, XXXXX | | 9. AGE (in years last birthday) 68 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME MORRIS GOLDBERG | | | | | 14. MOTHER'S MAIDEN NAME KATIE COHEN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 230-07-1915 | | 17. INFORMANT ADDRESS MRS. SARA C. LIPSITT, 3321 SHELburne RD. #8 | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Ventricular Fibrillation | | | | | | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction | | | | | | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | |
| (C) _____ | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (4) (this hospital) attended the deceased from Jan. 17 1971 to Jan. 21 1971 that (4) (we) last saw the deceased alive on Jan. 21 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Jan Sunshine M.D. | | | | | 23B. DATE SIGNED Jan. 21, 1971 | | | 23C. PHYSICIAN'S NAME (Type) IAN SUNSHINE M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 1-22-71 | | 24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON) | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | | 25B. NAME OF REGISTRAR Robert E. Seligson | | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | |

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF PHYSICS

AND
THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF PHYSICS

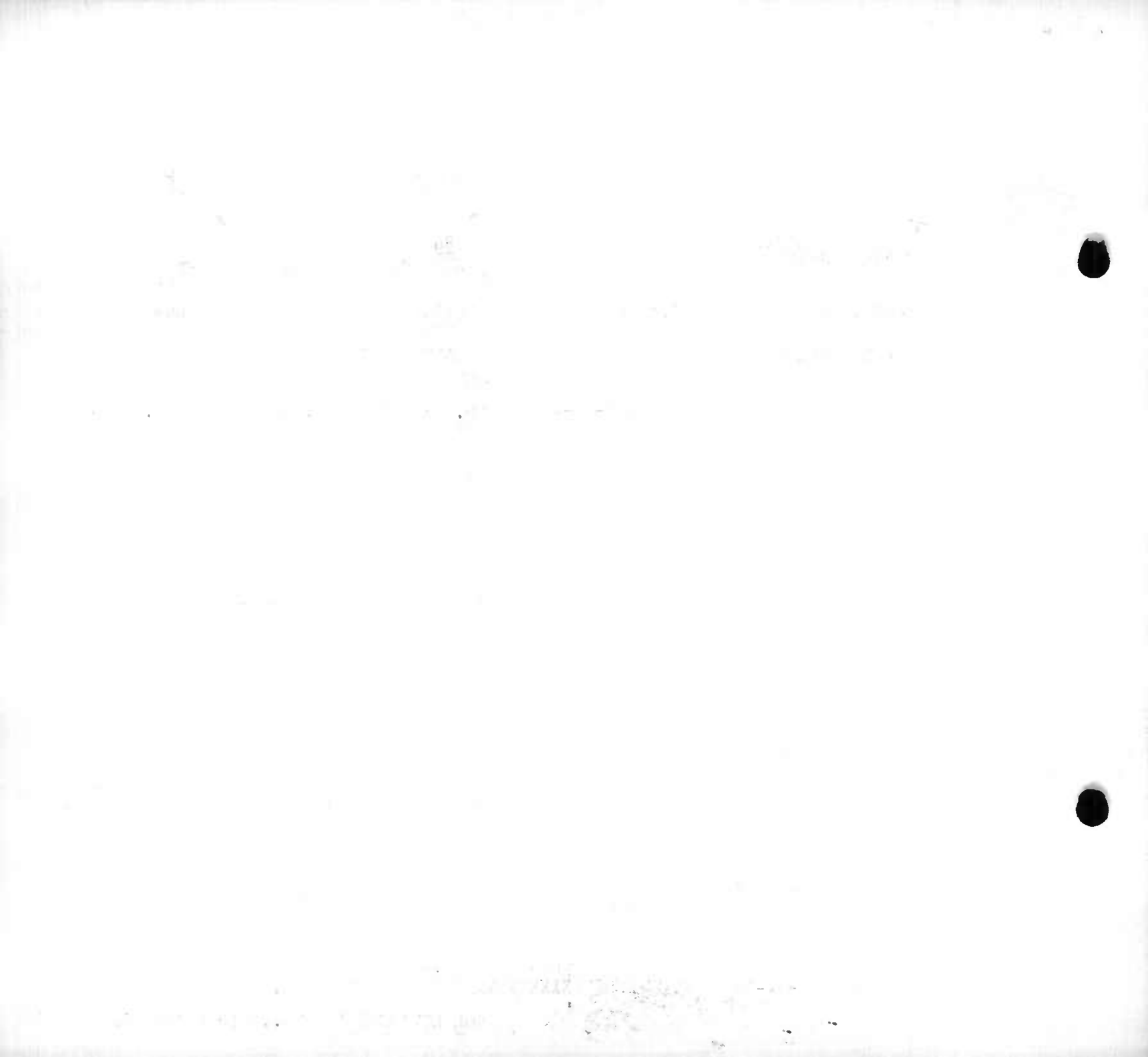
BY
J. J. THOMSON
AND
J. J. THOMSON

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF PHYSICS
AND
THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF PHYSICS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0738</u> | |
|--|---|---|--|---|---|
| B-250 71 0738 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>BIEGUN, JACOB.</u> | | 2. DATE AND HOUR OF DEATH <u>21st Jan. 1971 11:45 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u> Md. </u> B. COUNTY <u> 27-17 </u> | | C. CITY OR TOWN <u> Baltimore </u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore Inc.,</u> | | E. STREET AND NUMBER <u>2500 W Belvedere Ave</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/28/98</u> | 9. AGE (In years last birthday) <u>72</u> | 10. Under 1 Yr. Months: <u>3</u> Days: <u>3</u> Hours: <u>3</u> Min. <u>3</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIRMAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>LEATHER GOODS</u> | | 11. BIRTHPLACE (State or foreign country) <u>POLAND</u> | |
| 13. FATHER'S NAME <u>CHARLES BIEGUN</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ?</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-05-6939A</u> | | 17. INFORMANT <u>MRS. MIGNON SOBER, 3306 NERAK RD.</u> | |
| 18. <u>4/10/91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Myocardial Infarction and</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiogenic Shock.</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>21 days.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Atherosclerotic Cardiovascular Disease -</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>10 - 15 yrs.</u> | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Gastrointestinal haemorrhage</u> | | | | <u>6 days.</u> | |
| 19A. DATE OF OPERATION <u>2</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-31-1970</u> to <u>1-21-1971</u> that (I) (we) last saw the deceased alive on <u>1-21-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Prasad</u> | | 23B. PHYSICIAN'S NAME (Type) <u>P. PRASAD</u> | | 23C. DATE SIGNED <u>1/21/71</u> | |
| 23D. ADDRESS <u>Sinai Hospital of Baltimore, md 21215.</u> | | 23E. DEGREE <u>MBBS</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>1-22-71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>PROGRESSIVE BUDOMER VEREIN</u> | 24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u> | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>SOLO LEVINSON & BROS.</u> | | 25C. FUNERAL DIRECTOR <u>6010 REISTERSTOWN ROAD</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

B. Sol Levin

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF INSTITUTION)

Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

7-03

6. SEX

male

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2333 E. Monument St.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

JACOB LEVIN

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MERCHANT

14B. KIND OF BUSINESS OR INDUSTRY

RETAIL

15. MOTHER'S MAIDEN NAME

I REBECCA ANSELOWITZ

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.
219-32-0845

18. INFORMANT

ADDRESS

MR. LEONARD LEVINE, 3503 GARDENVIEW RD. #8

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/22/71

24A. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL

24B. DATE

1-22-71

24C. NAME of CEMETERY or CREMATORY

BOBROISKER BENEFICIAL

24D. LOCATION (City, town, or county)

ROSEDALE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

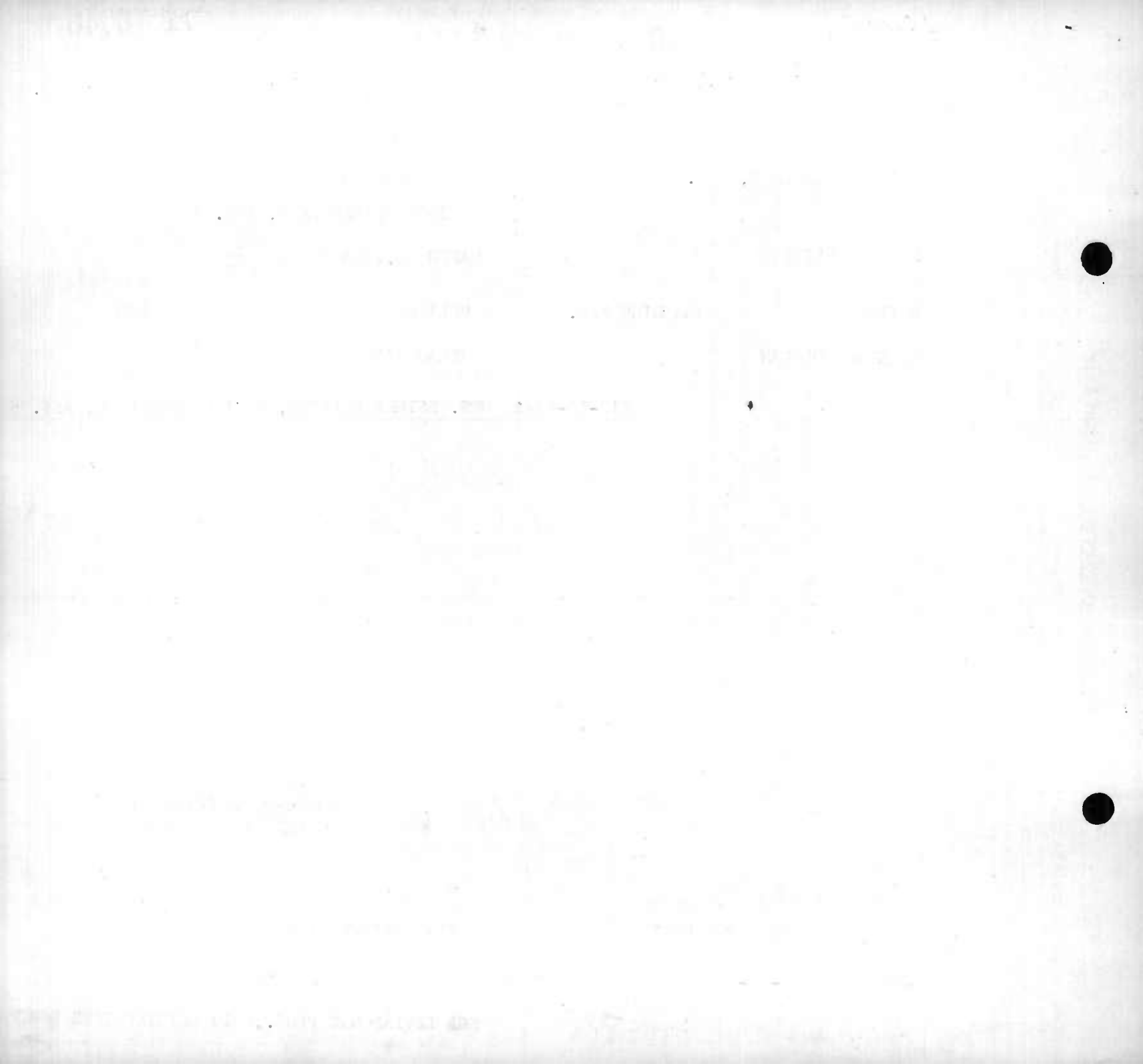
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

letter from M.E. Office 111 Penn St. Stating father was Married.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

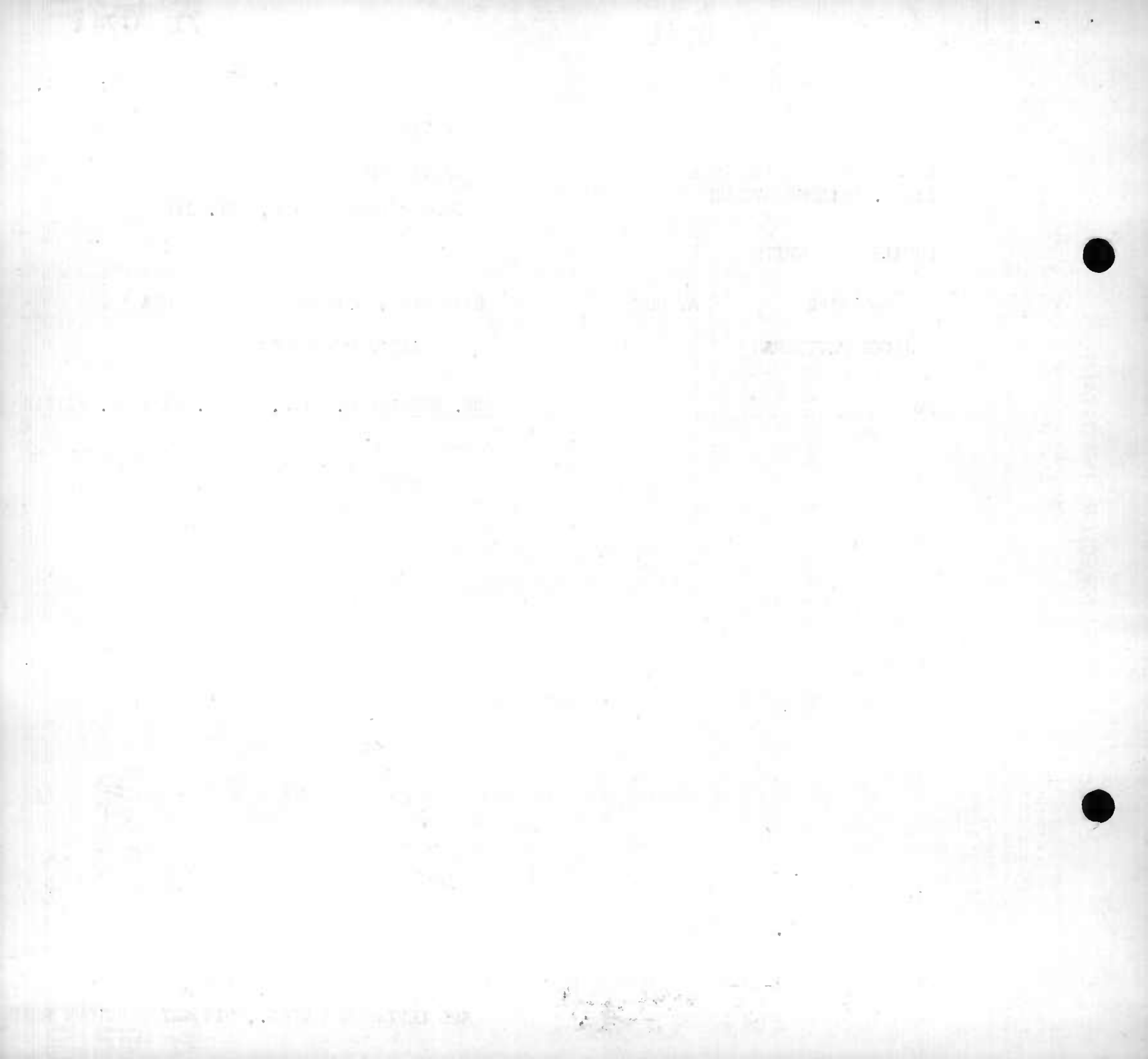
| G-435 71 0740 | | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0740 | |
|--|-------------------------|---|---|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) ABRAHAM GOLDMAN | | | | 2. DATE AND HOUR OF DEATH JANUARY 19, 1971 | | 10:35 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3921 CLARKS LANE, APT. B | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-20 | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3921 CLARKS LANE, APT. B | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 26, 1888 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG. | | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ISADORE GOLDMAN | | | 14. MOTHER'S MAIDEN NAME SARAH JACOBS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 212-10-8848 | | 17. INFORMANT ADDRESS MRS. ESTHER GOLDMAN, 3921 CLARKS LANE, APT. B | | |
| 18. 412, 314-163, 0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure A.S.H.D. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 70 yrs. | |
| | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Possible metastatic Ca to pleura | | ? | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 1/19/71 to 1950 present that (2) we last saw the deceased alive on 1/19/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (4) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Bernard Burgin M.D. DEGREE | | | | 23B. DATE SIGNED 1/20/71 | | 23C. PHYSICIAN'S NAME (Type) BERNARD BURGIN | |
| 23D. ADDRESS 3809 CLARKS LANE | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-21-71 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR John E. [illegible] | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. | | ADDRESS 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0741 |
|--|-----------------------------|--|---|--|
| 1. NAME OF DECEASED (Type or Print) BERTHA HETTLEMAN | | 2. DATE AND HOUR OF DEATH JANUARY 20, 1971 8:15 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LONG GREEN NURSING HOME 115 E. MELROSE AVENUE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 13-07 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3939 ROLAND AVENUE, APT. 219 | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 70 | 9. AGE (In years last birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JACOB HETTLEMAN | | |
| 14. MOTHER'S MAIDEN NAME LEIDA HETTLEMAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MRS. ROSALIE H. OTTO, 810 E. 41st St. #21218 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.21 CAUSE OF DEATH Hypertensive Cardio-Vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 6 years (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from December 8 1970 to January 20 1971 , that (I) (we) last saw the deceased alive on January 17 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE W. Grafton HERSPERGER DEGREE | | | | 23B. DATE SIGNED January 20, 1971 |
| 23C. PHYSICIAN'S NAME (Type) W. GRAFTON HERSPERGER | | 23D. ADDRESS MEDICAL ARTS BUILDING | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 1-21-71 | 24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Chas E. Kelly, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0742 |
|--|--------------------------------|--|--|---|
| 1. NAME OF DECEASED (Type or Print) <i>Sophie Morgenstern</i> | | 2. DATE AND HOUR OF DEATH <i>1/20/71</i> <i>7:30 A</i> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>33</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>The Johns Hopkins Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-20</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3811 Seven Mile Lane</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>XXXXXX</i> | 9. AGE (In years last birthday) <i>77</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>CHAIM</i> <i>XXXXXXXX Zimmerman</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Minda XXXXXXXX ?</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | |
| 16. SOCIAL SECURITY NO. <i>218-22-9805</i> | | 17. INFORMANT <i>MR. HAROLD MORGENSTERN, BOX 43A, RT. 2, MONKTON, MD</i> | | |
| CAUSE OF DEATH | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>712.4 + 15.0X</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| (A) IMMEDIATE CAUSE <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| (C) | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Esophageal Carcinoma</i> | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | (If in Baltimore City, give exact location) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (1) this hospital attended the deceased from <i>1/5/71</i> to <i>1/20/71</i>, that (1) we last saw the deceased alive on <i>1/19/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <i>KL Taw Jr MD</i> | | | | 23B. DATE SIGNED <i>1/20/71</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>Richard L. Taw Jr MD</i> | | 23D. ADDRESS <i>601 N. Broadway Baltimore Md</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE <i>1-21-71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>BETH TFILOH</i> |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1971</i> | | |
| 25B. NAME OF REGISTRAR <i>SOL LEVINSON</i> | | 25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i> | | |

Seven mile L_a

CERTIFICATE OF DEATH

REG. NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 71 0743

BIRTH NO. 71 0743

1. NAME OF DECEASED (Type or Print) ETHEL M. WILLIAMS

2. DATE AND HOUR OF DEATH 1/20/71 1735 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES ☐ NO ☒

E. STREET AND NUMBER 2513 Wagner Ave. Baltimore, Md. 21219 005

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave. 31 Baltimore, Md. 21224

5. SEX Female 6. RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 10-30-90 9. AGE (In years last birthday) 80 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) England 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Harvey Philpotts 14. MOTHER'S MAIDEN NAME Eliya

15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 218-22-5943 17. INFORMANT BCH Records: Baltimore, Md. 21224 ADDRESS 4940 Eastern Ave.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ACUTE MYOCARDIAL INFARCT

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD

ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES MELLITUS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks ~20 years ~10 years

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Involuntarily medical examiner 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

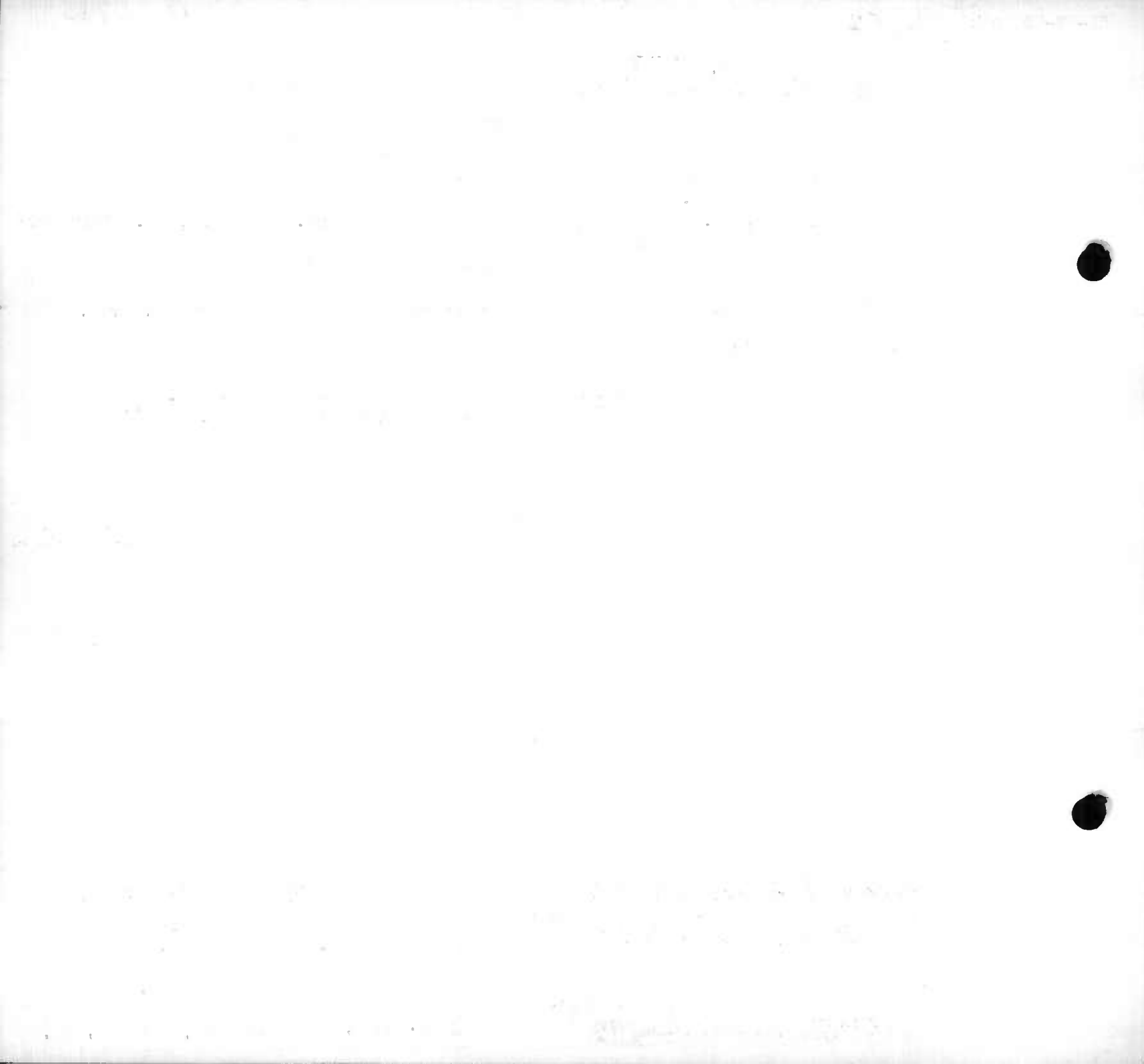
22. I certify that (I) (this hospital) attended the deceased from 1/5 19 71 to 1/20 19 71 that (I) (we) lost saw the deceased alive on 1/20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Richard K. Maza, MD DEGREE 23B. DATE SIGNED 1-20-71

23C. PHYSICIAN'S NAME (Type) RICHARD K. MAZA M.D. DEGREE 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/23/71 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. 25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0744</u> | |
|---|-------------------------|---|---|---|--|
| BIRTH NO. <u>R-320</u> | | 71 0744 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MR. HENRY ALBERT RATSCH | | | 2. DATE AND HOUR OF DEATH <u>1/20/71</u> <u>8:30 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231 | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>Edgemere</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 3019 RITCHIE AVENUE | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/28/07</u> | 9. AGE (In years last birthday) <u>63</u> <u>yes.</u> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME HENRY RATSCH | | | |
| 14. MOTHER'S MAIDEN NAME ALMA BUTZKE | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>213-09-3486</u> | | 17. INFORMANT (WIFE) MARY KATHARYN RATSCH | | ADDRESS 3019 RITCHIE AVE. 21219 | |
| 18. <u>250.71</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>acute renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>uremia & GI bleeding, arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes mellitus, Femoral artery embolism.</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>1/11/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Femoral embolectomy</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/8/71</u> 19 <u>70</u> to <u>1/20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/20</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>A.C. Chouvalit, M.D.</u> | | | | 23B. DATE SIGNED <u>1/20/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>A.C. CHOUVALIT, M.D.</u> | | | | 23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/25/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>John J. Duda</u> | | 25C. FUNERAL DIRECTOR <u>John J. Duda</u> | | | |
| 25D. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u> | | | | | |

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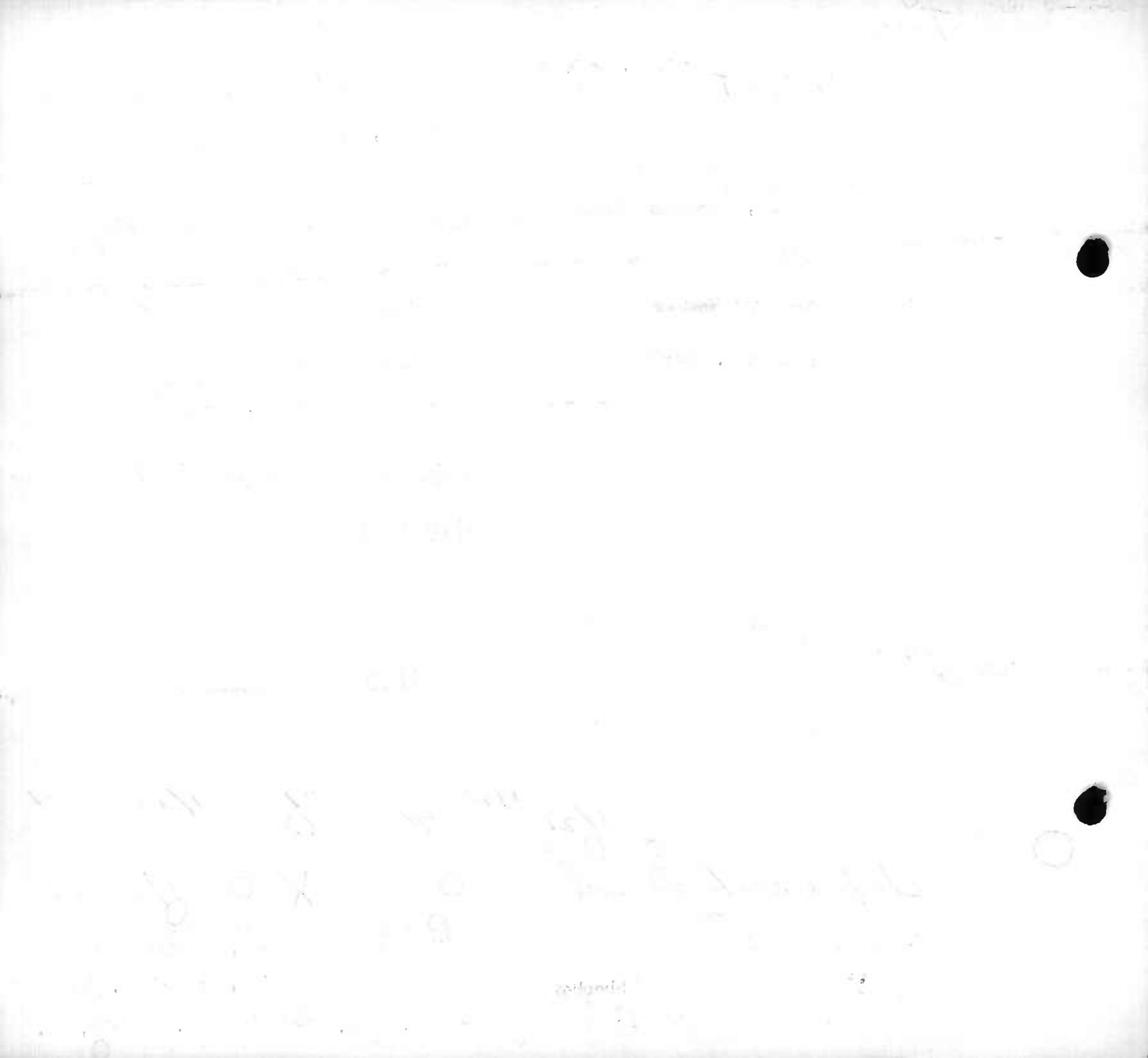
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

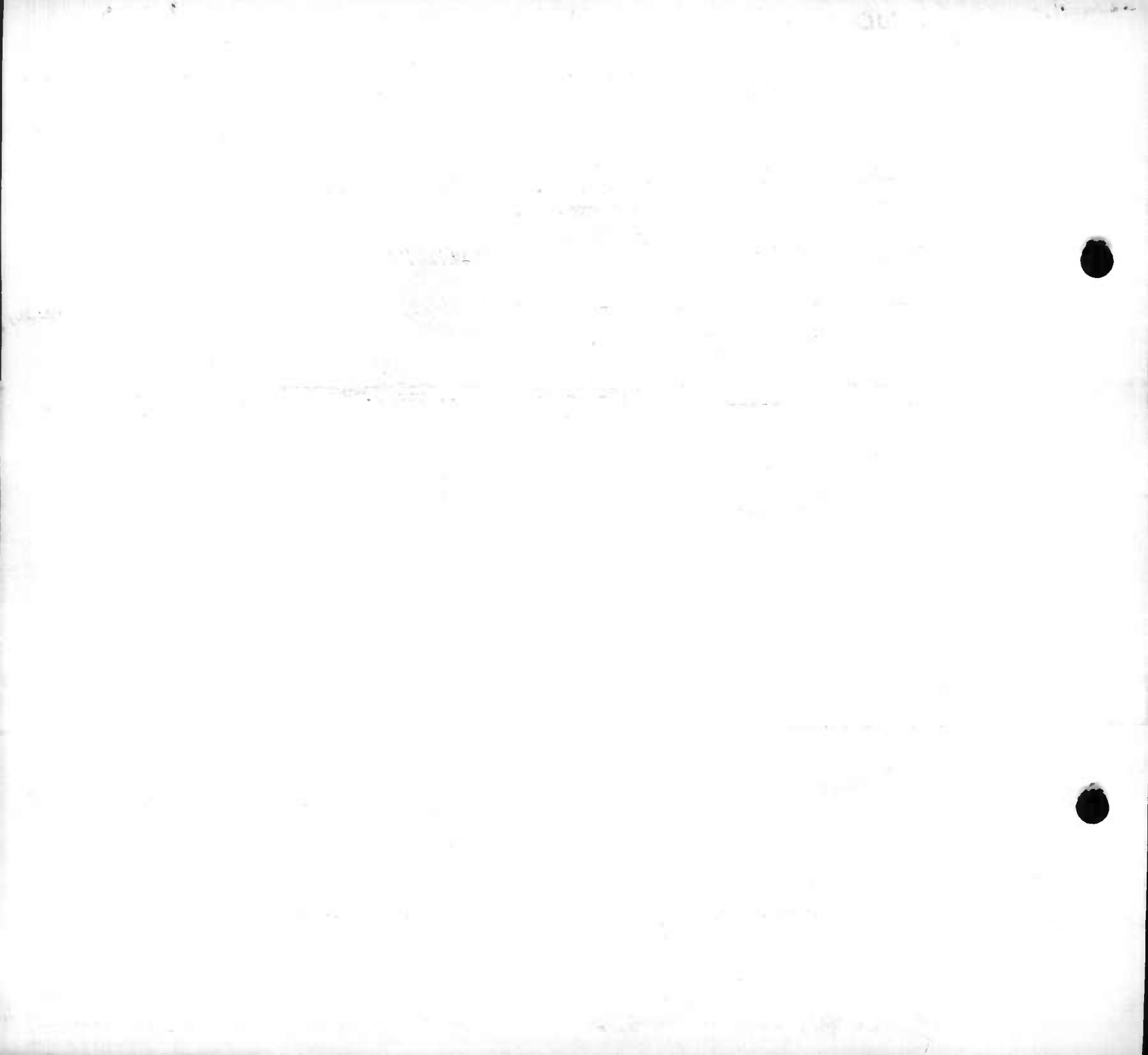
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0745 | |
|--|---|--|--|--|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) TOLBERT JOHN W. | | CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH 1/21/71 12:20 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland , B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1908 Washington Road 21222 005 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-5-85 | 9. AGE (in years last birthday) 85 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cotton Mill Worker |
| 11. BIRTHPLACE (State or foreign country) Virginia | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Frank W. Tolbert | | | 14. MOTHER'S MAIDEN NAME Mary Manuel | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-01-6890 | 17. INFORMANT 4940 Eastern Avenue ADDRESS BCH-Records Baltimore, Maryland 21224 | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div style="width: 10%; text-align: right;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hrs. </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/20 19 70 to 1/21 19 71 that (I) (we) last saw the deceased alive on 1/21 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Jeremiah Duwel | | | | 23B. DATE SIGNED 1/21/71 | |
| 23C. PHYSICIAN'S NAME (Type) J. Jeremiah Duwel | | 23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/25/71 | 24C. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery | | 24D. LOCATION (City, town, or county) (State) Ellicott City, Howard Co. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

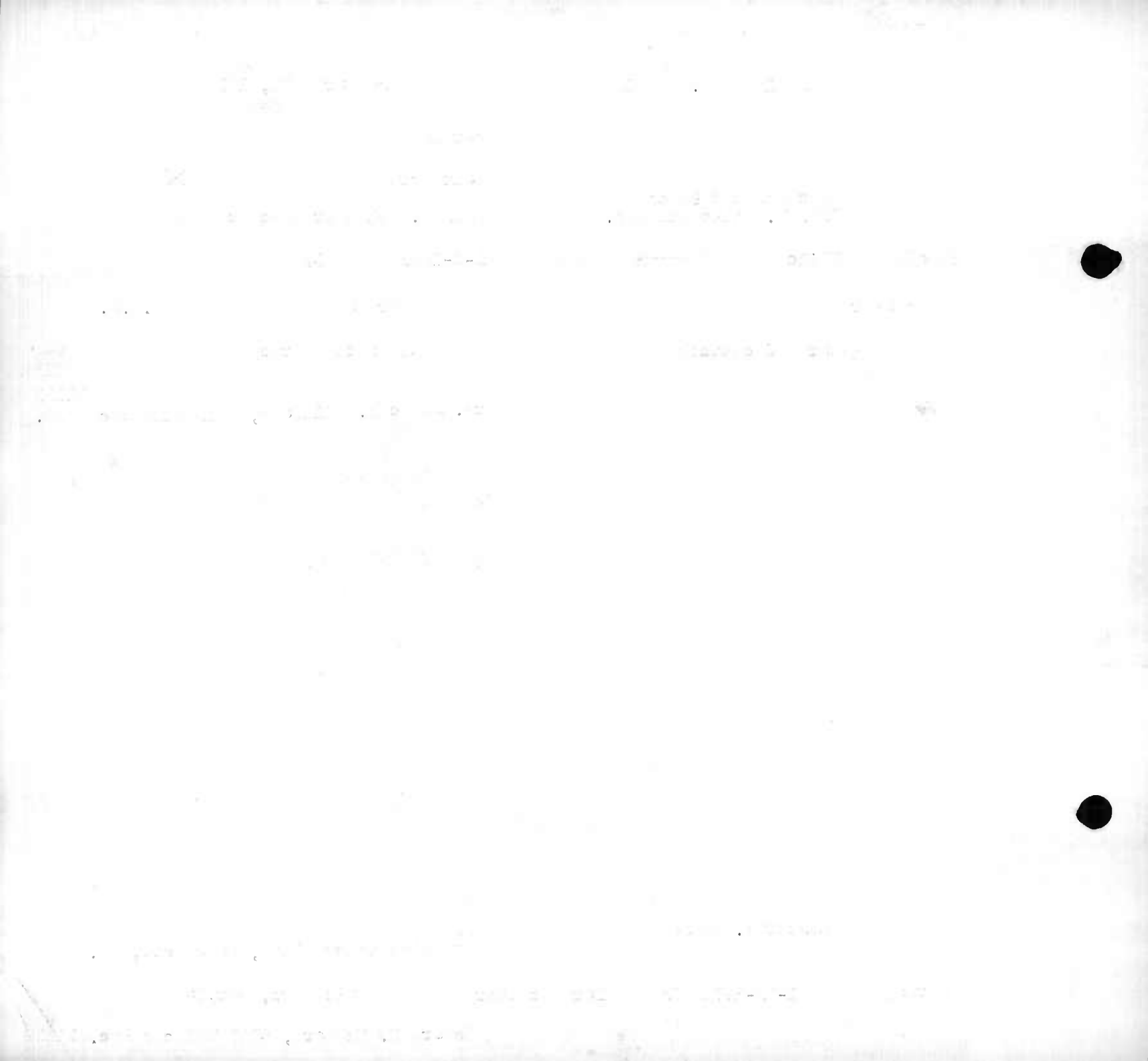
| | | | | | | | |
|--|----------------------|---|----------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 8-300 | | 71 0746 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0746 | |
| 1. NAME OF DECEASED (Type or Print) Charles George Ruth Jr. | | | | 2. DATE AND HOUR OF DEATH 1/22/71 9:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hosp of Baltimore 42 Baltimore Md. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| C. CITY OR TOWN Randallstown 21133 | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 3704 Lamoine Rd. | | | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/26/14 | 9. AGE (In years last birthday) 56 56 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | | 10B. KIND OF BUSINESS OR INDUSTRY Blue Cross-Blue Shield | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? American S.A. | |
| 13. FATHER'S NAME Charles George Ruth Sr. | | | | 14. MOTHER'S MAIDEN NAME Margaret Shaffer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-03-3625 | | 17. INFORMANT Mrs. Irma K. Ruth | | ADDRESS 3704 Lamoine Road Randallstown, Md. 21133 | |
| 18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Renal failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of Colon & Metastases | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Renal failure (B) Carcinoma of Colon & Metastases (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 1-18-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pain | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-15 19 70 to 1-22 19 71 that (I) (we) lost saw the deceased alive on 1-22 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S. Bencharil | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) Sakda Bencharil | | | | 23D. ADDRESS Sinai Hospital of Baltimore Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Loring Byers | | ADDRESS 21133 8728 Liberty Rd. Randallstown, | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|----------------------|---|--|
| Baltimore City Health Department | | REG. NO. 71 0747 | |
| BIRTH NO. D-120 | | 71 0747 | |
| 1. NAME OF DECEASED (Type or Print) ADDIE B. DAVIS | | 2. DATE AND HOUR OF DEATH January 21, 1971 7:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines 2525 W. Belvedere Ave. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-17 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2525 W. Belvedere Avenue | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-8-1883 9. AGE (In years lost birthday) 87 10. UNDER 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard Chenoweth | | 14. MOTHER'S MAIDEN NAME Elizabeth Dorsey | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Addie B. Williams, 9035 Allenswood Rd. | | ADDRESS 21133 | |
| 18. 41241 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2/20/68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED stroke 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 1/20/71 to 1/21/71 19_____ that (I) (we) lost saw the deceased alive on 1/20/71 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Lester N. Kolman DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED 1/21/71 23C. PHYSICIAN'S NAME (Type) Lester N. Kolman 23D. ADDRESS 6821 Reisterstown Road, Baltimore, Md. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-25-1971 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 25B. NAME OF REGISTRAR Robert J. Hubbard 25C. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

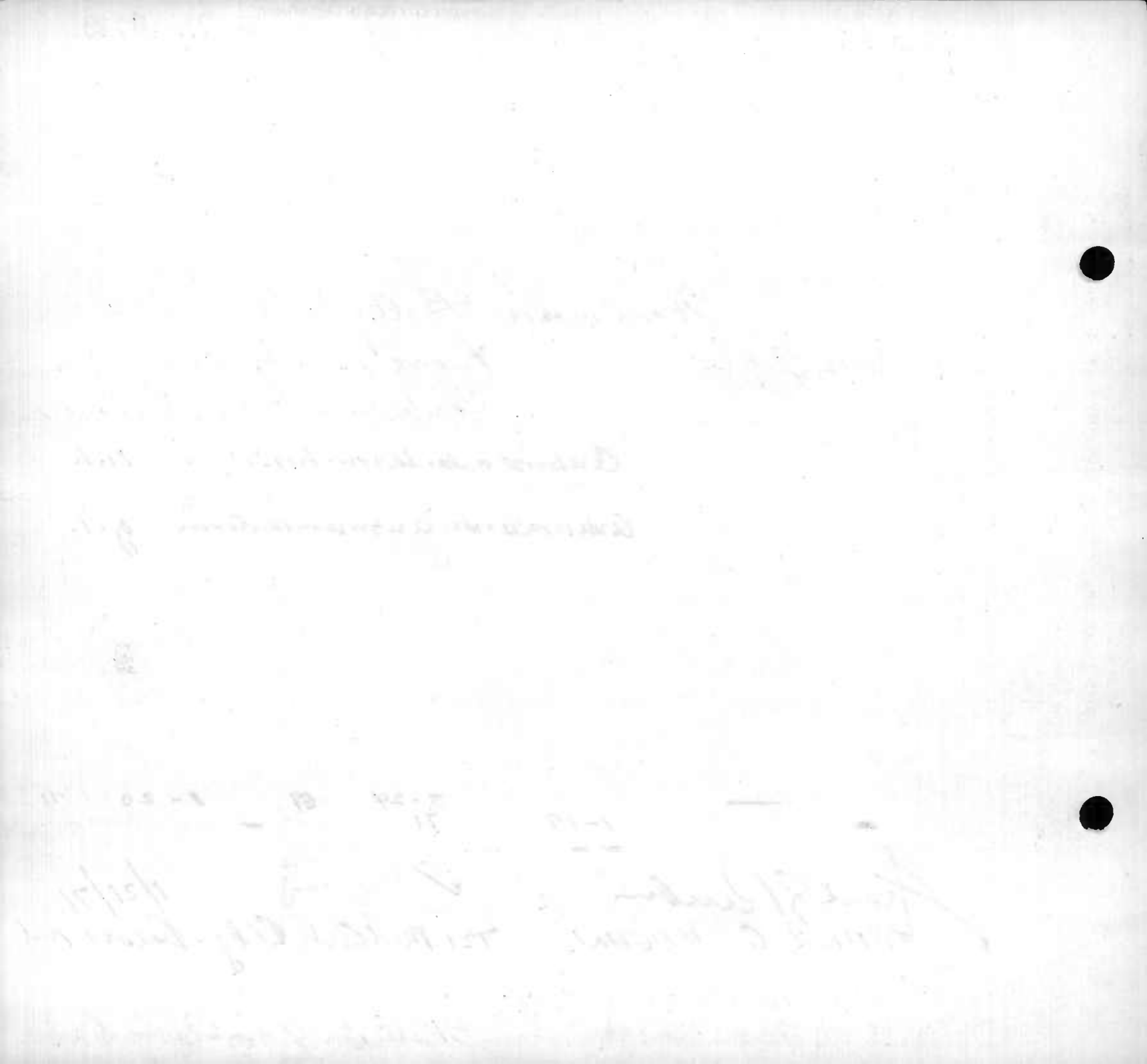
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0748 | |
|--|---|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> H-425 71 0748 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) HOLSINGER, ORVILLE E. | | 2. DATE AND HOUR OF DEATH 1/22/71 3³⁰ A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 2-1-71 SINAI HOSPITAL OF BALTIMORE | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 5323 CLIFTON AVE 21207 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/1/04 | 9. AGE (In years last birthday) 66 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10B. KIND OF BUSINESS OR INDUSTRY Chieftain Pontiac Co. | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME John W. Holsinger | | 14. MOTHER'S MAIDEN NAME Minnie E. Mason | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No | | 16. SOCIAL SECURITY NO. 216-03-2548 | | 17. INFORMANT Mrs. Helen P. Holsinger, 5323 Clifton Ave. | |
| 18. 201X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HOOGKIN'S DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3 YRS. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-8-1971 to 1-22-1971 that (I) (we) last saw the deceased alive on 1-22-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert M. M... M.D. | | | | 23B. DATE SIGNED 1/22/71 | |
| 23C. PHYSICIAN'S NAME (Type) SHELDON KRAVITZ M.D. | | 23D. ADDRESS DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-25-1971 | | 24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | |
| | | | | ADDRESS 4107 Wilkens Ave. 21229 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 0749 | |
|--|--|---|--|---|--|--|--|
| BIRTH NO. M-242 | | | | 71 0749 | | | |
| 1. NAME OF DECEASED (Type or Print) MICHELSON IDA JULES | | | | 2. DATE AND HOUR OF DEATH 1/20/71 | | 9⁴⁵ AM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION PLEASANT MANOR NURSING HOME ADDRESS OR LOCATION 4615 PARK HGTS AVE BALTIMORE, MD 21215 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 13-01 | | | |
| 5. SEX F | | 6. RACE CAU | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-20-86 | |
| 9. AGE (In years lost birthday) 84 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) Balto Md | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Charles Jules | | | | 14. MOTHER'S MAIDEN NAME Lena Neuberger | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 217-13-6733 | | 17. INFORMANT Charles Jules Michelson | |
| 18. 4 33.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular thrombosis. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cerebrovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk g.i.s. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-24 1969 to 1-20 1971 , that (I) last saw the deceased alive on 1-19 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Frank G. Kuehn | | | | 23B. DATE SIGNED 1/21/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) FRANK G. KUEHN | | | | 23D. ADDRESS 721 Med Arts Bldg. Balto 1 md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/71 | | 24C. NAME OF CEMETERY or CREMATORY Haven Friendship Bldg | | 24D. LOCATION (City, town, or county) (State) Baltimore MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. J. ... | | 25C. FUNERAL DIRECTOR William G. Fickner & Sons | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 0750</u> | |
|---|--|---|--|---|--|--|--|
| Y-252 | | 71 0750 | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>AUGUST M VASINSKI</u> | | | | 2. DATE AND HOUR OF DEATH <u>JAN. 21, 1971 2:05 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>16-07</u> | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-15-87</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>VASINSKI</u> | | | | 14. MOTHER'S MAIDEN NAME <u>2</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>216-07-2383</u> | | 17. INFORMANT <u>Lutheran Hospital Records</u> | | ADDRESS | |
| 18. <u>445.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>? PULMONARY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: EMBOLISM</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) GANGRENE @ FOOT AMPUTATED - Arteriosclerotic HD.</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <u>1-14-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>cellulitis of foot</u> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-13-1970</u> to <u>1-21-1971</u> that (I) (we) last saw the deceased alive on <u>1-21-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Sunan Vongkasemsiri</u> | | | | 23B. DATE SIGNED <u>1-21-71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>SUNAN VONGKASEMSIRI</u> | | | | 23D. ADDRESS <u>LUTHERAN HOSP. OF MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1/23/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Louisa McCom</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talbot</u> | | 25C. FUNERAL DIRECTOR <u>Thomas J. Kenny/Inc.</u> | | ADDRESS <u>1600 Hollins</u> | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 71 0751 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Walter Young | | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 23 71 1:20 a. | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital | | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 23 71 1:20 a. | | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-02 | | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 6. SEX male | | 7. RACE white | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | |
| 9. DATE OF BIRTH 5/19/1900 | | 10. AGE (in years last birthday) 70 | | 11. BIRTHPLACE (State or foreign country) md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Young | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter | | 15. MOTHER'S MAIDEN NAME Leahor? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 17. SOCIAL SECURITY NO. ? | | 18. INFORMANT Mary Sullivan | | ADDRESS above | | | | | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION 2/26/71 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes | | | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1447 Washington Blvd. | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12 26 70 noon m. | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? fell down steps apparently following consumption of alcohol. | | | | | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. DATE SIGNED 1/23/71 EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | | 24C. NAME OF CEMETERY or CREMATORY Green Haven Cem. | | 24D. LOCATION (City, town, or county) (State) Green Haven Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR John J. Cavanagh & Son Inc. | | ADDRESS 901 St. Johns St. Md. | | | |

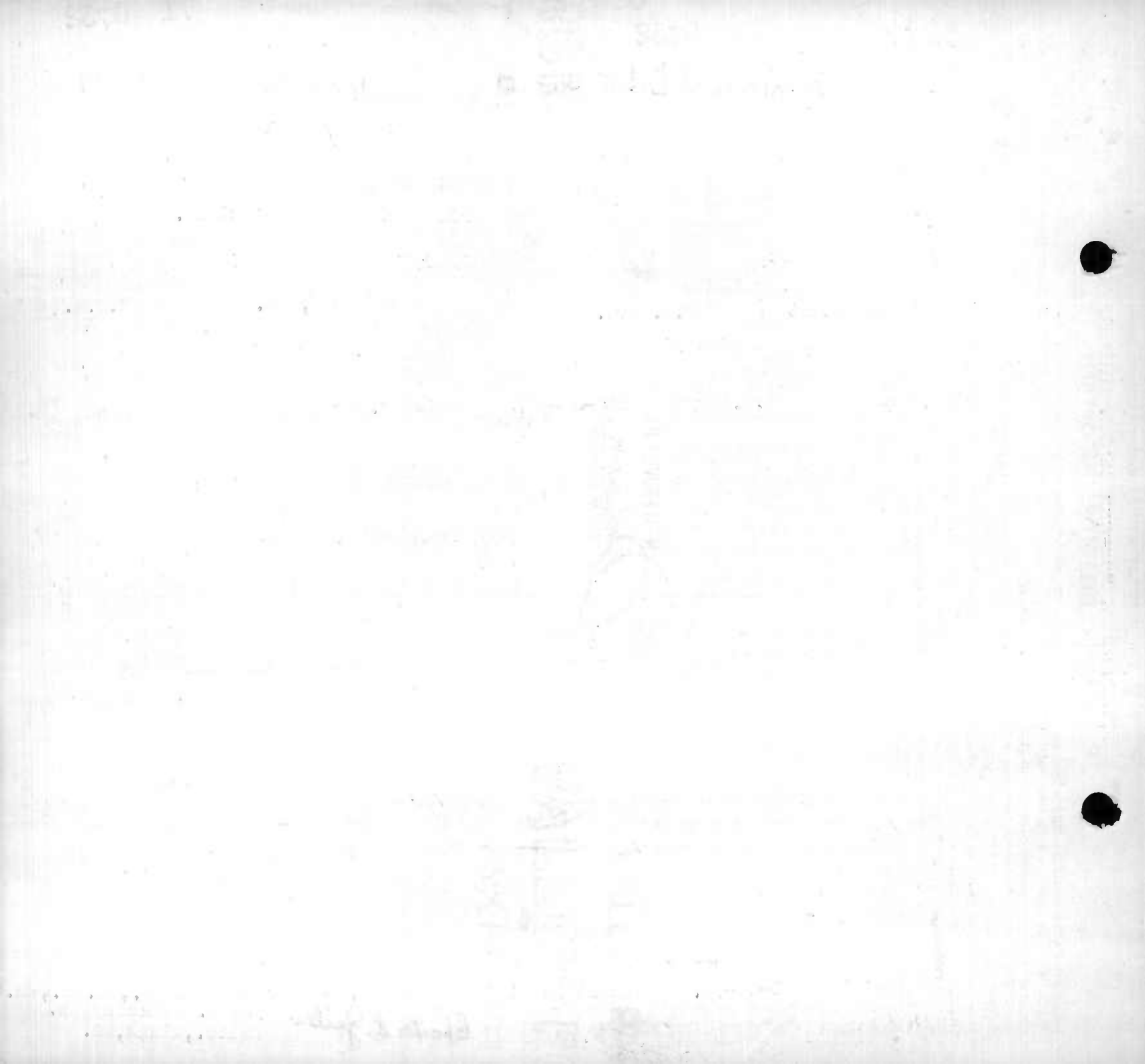
ALCANTARA

ON APPROVAL

RELEASED AS NON-MED BY DR. MIHALAKIS
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. <u>D-420</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71 0752</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Dominic J. DiLeggi</u> | | 2. DATE AND HOUR OF DEATH <u>1/22/71</u> at <u>10:29 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Essex</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>338 Ida Avenue # 21221.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/03/27</u> | 9. AGE (In years last birthday) <u>43</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>Anthony DiLeggi</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>U.S. Navy</u> | | 16. SOCIAL SECURITY NO. <u>216-20-5674</u> | | 17. INFORMANT <u>Louise J. DeLeggi</u> | |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease or complication which caused death.) <u>Cardio-pulmonary Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. <u>Myocardial Infarction</u> | | CAUSE OF DEATH A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Same</u> | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>1</u> (this hospital) attended the deceased from <u>1/22</u> 19 <u>71</u> to <u>1/22</u> 19 <u>71</u> , that <u>1</u> (we) last saw the deceased alive on <u>DOA</u> 19 <u>71</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>1</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Paul Whelton</u> | | 23B. DATE SIGNED <u>1/22/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>PAUL WHELTON M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-25-71.</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>7401 German Hill Rd., Ba. Co., Md.</u> | | 24E. FUNERAL DIRECTOR <u>Charles S. Jailer</u> | | 24F. ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Charles S. Jailer</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. [REDACTED] |
|--|--------------------------------|---|---|---|
| BIRTH NO. <div style="font-size: 2em; font-weight: bold;">R-563</div> | | <div style="font-size: 2em; font-weight: bold;">71 0753</div> | | <div style="font-size: 2em; font-weight: bold;">71 0753</div> |
| 1. NAME OF DECEASED (Type or Print) <i>CHARLES A. REINHART</i> | | | 2. DATE AND HOUR OF DEATH <i>1-21-71 2:30 P. M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>11-02</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>712 Cathedral St.</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-14-24</i> 9. AGE (In years last birthday) <i>86</i> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>salesman (ret.)</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Distillery</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Henry Reinhart</i> <i>Not known</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Caroline (unknown)</i> <i>no known</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | |
| 16. SOCIAL SECURITY NO. <i>217 14 6775A</i> | | 17. INFORMANT ADDRESS <i>Mr. Howard V. Jones Ferndale, Md.</i> | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-14-71</i> to <i>1-21-71</i> that (I) (we) last saw the deceased alive on <i>1-21-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <i>MARIELY NAPIZA M.D.</i> | | | 23B. DATE SIGNED <i>1-21-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Mariele Napiza</i> | | | 23D. ADDRESS <i>Union Memorial Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Jan. 23/70</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Western Cemetery</i> |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1971</i> | | |
| 25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Singleton Funeral Home Glen Burnie, Maryland</i> | | |

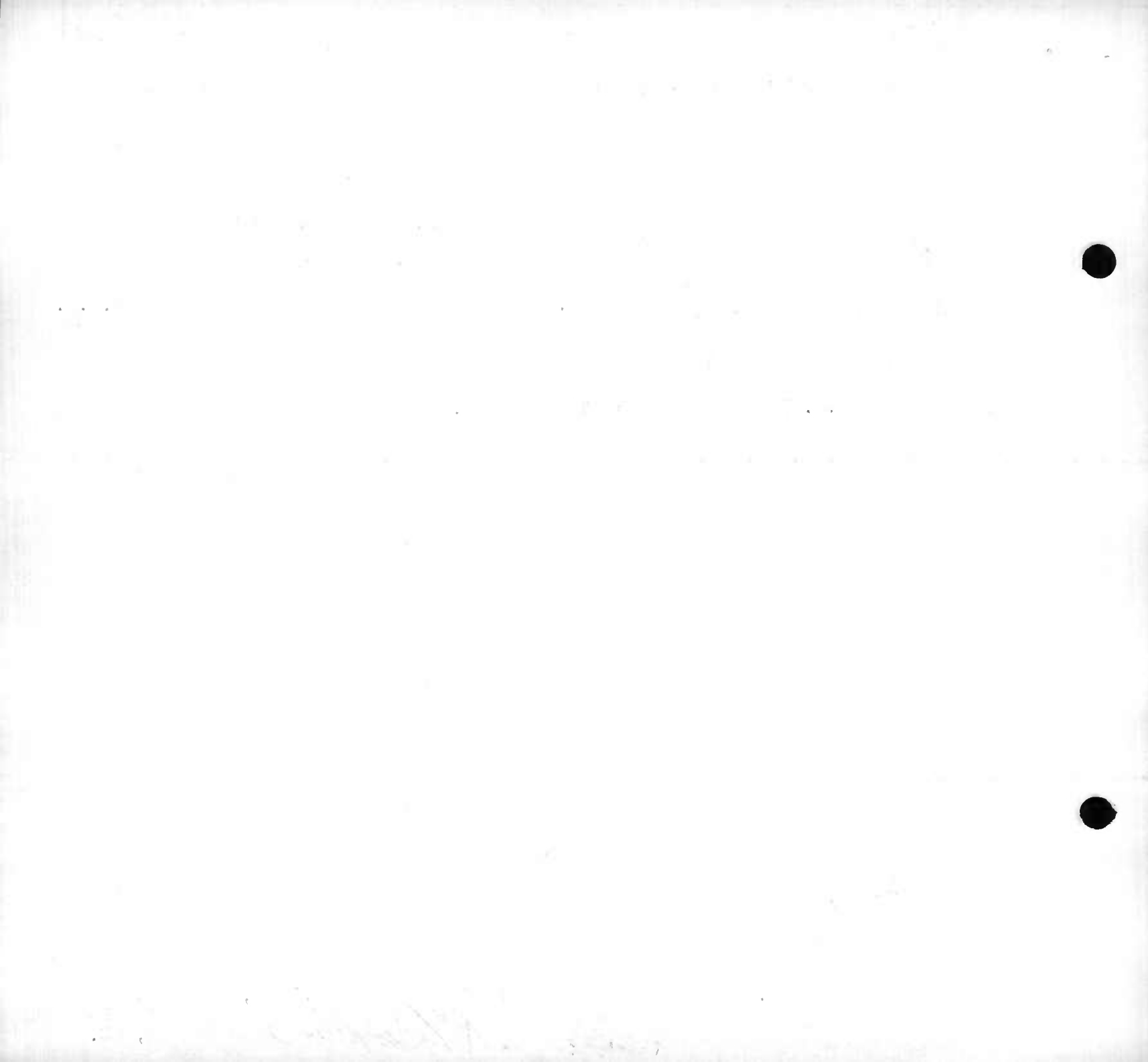
[REDACTED]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

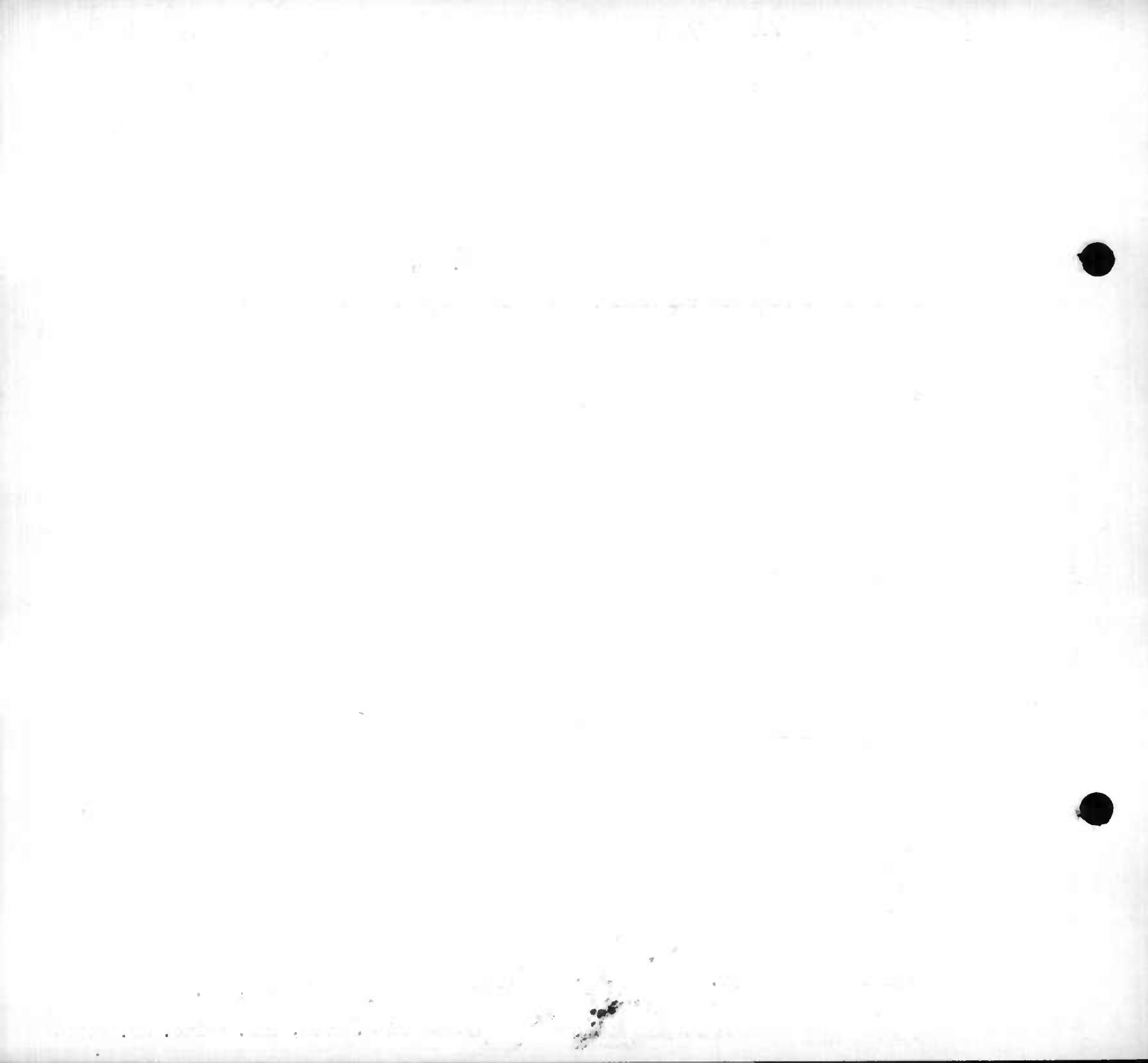
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0754</u> | |
|--|------------------|---|--|--|--|
| BIRTH NO. <u>B-660 71 0754</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Brewer-Arnold</u> | | | 2. DATE AND HOUR OF DEATH <u>1-22-71 5:15 AM</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MAINE</u> B. COUNTY <u>LINCOLN</u> C. CITY OR TOWN <u>BOOTHBAY HARBOR</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>52 ATLANTIC AVENUE</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 10/92</u> | 9. AGE (In years last birthday) <u>78</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired GROCERY STORE PROPRIETOR</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>MAINE</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>EDWARD BREWER</u> | | | 14. MOTHER'S MAIDEN NAME <u>SUSAN BREWER</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W.W. 1</u> | | | 16. SOCIAL SECURITY NO. <u>004 34 5949</u> | | |
| 17. INFORMANT <u>MRS. MADELINE BREWER (wife)</u> | | | ADDRESS <u>Same As #4</u> | | |
| 18. <u>4-12-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ARTERIOSCLEROSIS HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>METABOLIC ALKALOSIS</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-6-71</u> 19__ to <u>1-22-71</u> 19__ that (I) (we) last saw the deceased alive on _____ 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Aye Ngwe</u> | | | 23B. DATE SIGNED <u>1-22-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Aye Ngwe</u> |
| 23D. ADDRESS _____ | | | 23E. DEGREE _____ | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>JAN. 26/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>OCEAN VIEW CEMETERY</u> | |
| 24D. LOCATION <u>BOOTHBAY, MAINE</u> | | 24E. STATE <u>MAINE</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Robert E. Johnson</u> | |
| 25D. ADDRESS <u>SINGLETON FUNERAL HOME</u> | | 25E. CITY <u>BOOTHBAY HARBOR</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0755 | |
|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. 71 0755 | |
| BIRTH NO. <u>5-610</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>SCHARFE, Mr. OSCAR</u> | | | 2. DATE AND HOUR OF DEATH <u>1.23, 1971</u> <u>2.15 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home & Hospital</u> <u>Baltimore Maryland 21231</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> <u>53-00</u> | | |
| 5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>Jan. 28, 1895</u> 9. AGE (In years last birthday) <u>75 yrs.</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd. tool & dye maker</u> | | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | |
| 13. FATHER'S NAME <u>Gottlieb Scharfe</u> | | | 14. MOTHER'S MAIDEN NAME <u>Amelia Fried.</u> | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>214-05-4393</u> | | |
| 17. INFORMANT <u>Mable Scharfe</u> | | | ADDRESS <u>2910 Kingridge Rd. Balt.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>712.31</u> <u>Pulmonary Embolism (R)</u> <u>Bilateral pneumonia</u> <u>ASHD</u> <u>metastatic</u> | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 19. DATE OF OPERATION | | | 20A. AUTOPSY? (Yes or No) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 22. I certify that (this hospital) attended the deceased from <u>12.24</u> <u>1970</u> to <u>1.23</u> <u>1971</u> that (I) last saw the deceased alive on <u>1.23</u> <u>1971</u> and that (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Abdus Samad</u> <u>MD</u> | | | 23B. DATE SIGNED <u>1.23.1971</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ABDUS SAMAD</u> <u>MD</u> | | | 23D. ADDRESS <u>Church Home & Hospital Baltimore</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/26/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Leonard J. Ruck, Inc.</u> | | 25C. FUNERAL DIRECTOR <u>Balto. Md. 21214</u> | | | |



| C-450 | | 71 0756 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0756 | |
|--|------------------|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Louis R. Coliano | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 24 71 11:20 a.m. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 24 71 11:20 a.m. | | | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 27-68 | | | | | | | |
| 6. SEX male | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH May 13, 1913. | | 10. AGE (In years lost birthday) 57 | | E. STREET AND NUMBER 830 E. Lake Avenue | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Antonio Coliano | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 14B. KIND OF BUSINESS OR INDUSTRY Self-Employed | | 15. MOTHER'S MAIDEN NAME Stella ? | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 214-22-6498 | | 18. INFORMANT ADDRESS Mrs. Cornelia B. Coliano (Same) | | | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) No | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type): CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: 1/25/71 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/29/71. | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0757 | |
|---|------------------|--|-------------------------------------|---|--|
| M-163 71 0757 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Martin L. Mayfort</i> | | 2. DATE AND HOUR OF DEATH <i>January 24, 1971 2:40 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | |
| C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER <i>3305 Lerch Drive</i> | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-17-97</i> | 9. AGE (in years last birthday) <i>73</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher + Cabinet Maker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>John Mayfort</i> | | 14. MOTHER'S/MAIDEN NAME <i>Virginia Hutton</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Wife - Jane Mayfort - Same</i> | |
| 18. <i>492X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia + ? Septicemia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Emphysema</i> (C) <i>Subat. pleural effusion aspiration</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 yrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>2/2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/23</i> 19 <i>71</i> to <i>1/24</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>1/24</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>E. Eugene Page Jr.</i> | | 23B. DATE SIGNED <i>1/28/71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>E. Eugene Page Jr.</i> | |
| 23D. ADDRESS <i>Union Memorial Hospital</i> | | 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | | |
| 24B. DATE <i>1/28/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i> | |

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W-230 71 0758 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 0758

BIRTH NO.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) MELVIN LEE WIEST | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 23, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 23, 1971 1:05 P.M. | |
| 6. SEX Male | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-01 | |
| 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 1914 5/22/71 | 10. AGE (In years lost birthday) 56 | E. STREET AND NUMBER 400 N. Linwood Avenue | |
| 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | 13. FATHER'S NAME Edgar Wiest | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 148. KIND OF BUSINESS OR INDUSTRY Railroad | 15. MOTHER'S MAIDEN NAME Lillian | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | 17. SOCIAL SECURITY NO. 214 20 0359 | 18. INFORMANT ADDRESS Mrs. Estelle Wiest 400 N. Linwood Ave. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION | | 208. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH. | | 228. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) Yes | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 24, 1971 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/27/71 | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | 24D. LOCATION (City, town, or county) (State) Dorsey, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | 25B. NAME OF REGISTRAR Robert J. Ruck | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214 | |

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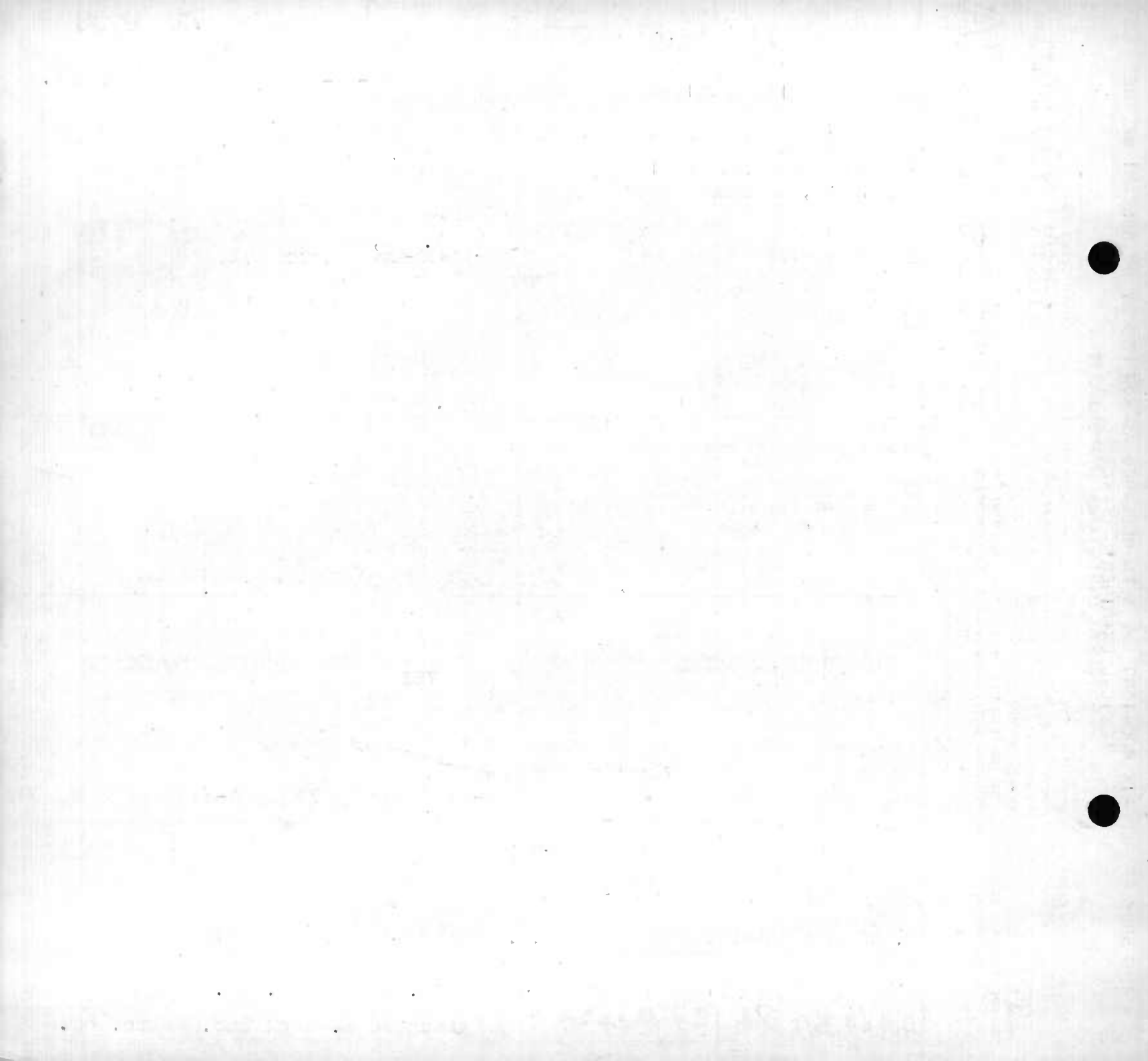
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THE BODY OF HENDRIK ROOSIORG HAS BEEN RELEASED AS NON MED BY DR BOLCARI OF THE

MEDICAL EXAMINER'S OFFICE
FURNAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

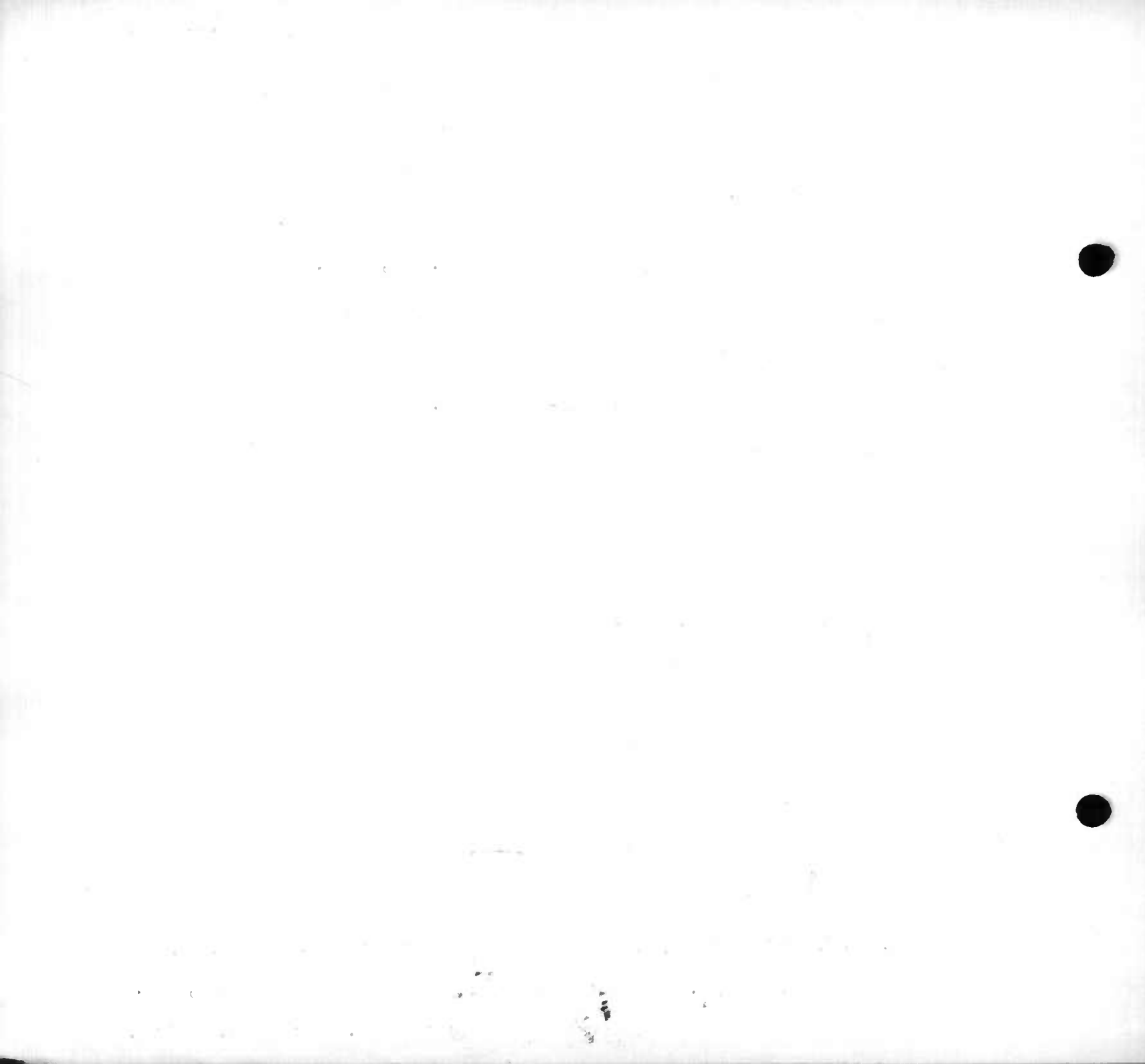
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| BIRTH NO. R-262 | | 71 0759 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0759 | |
| 1. NAME OF DECEASED (Type or Print) HENDRIK ROOSIORG | | | | 2. DATE AND HOUR OF DEATH 01-23-71 5:38 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-43 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3510 ELMORA AVE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 21, 1908 10-20-06 | 9. AGE (In years lost birthday) 62 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Estonia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John Roosiorg | | | | 14. MOTHER'S MAIDEN NAME Minna Viires | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Marta Roosiorg | | ADDRESS same | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery disease Generalized arteriosclerosis | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Generalized arteriosclerosis | | | |
| 19. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that Dr (this hospital) attended the deceased from 1-23 19 71 to 1-23 19 71 , that Dr (we) last saw the deceased alive on 1-23 19 71 and that in Dr (our) opinion death occurred on the date and hour and from the causes stated above. Dr (We) (did) (do not) view the body after death. | | | | | | | |
| 23A. SIGNATURE M. Dewayne Andrews MD | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) M. DEWAYNE ANDREWS | |
| 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE RECD BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Andrews | | 25C. FUNERAL DIRECTOR Leonard B. Ruck Inc. Balto. Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0760 | |
|---|---|---|---|--|---|
| P-500 71 0760 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MINNA CATHERINE PENN | | January 23, 1971 10 10 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 6306 Harford Rd. | | | A. STATE Maryland | | |
| | | | B. COUNTY 27-47 | | |
| C. CITY OR TOWN Baltimore | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 6306 Harford Rd. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 13, 1880 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bakery Worker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Christian Hebbel | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 215-03-5432 | | 17. INFORMANT Mrs. Minna Dietz |
| | | | ADDRESS (Same) | | |
| 18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 60 to January 23 19 71 and that (I) was last saw the deceased alive on January 23 19 71 and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | 23B. DATE SIGNED 1/23/71 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. E. J. Alessi M.D. | | | 23D. ADDRESS 6217 Harford Rd., Balto. Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. Md 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0761 | |
|---|--|---|--|---|--|
| J-520 71 0761 | | | | REG. NO. [REDACTED] | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) RAYMOND JONES | | 2. DATE AND HOUR OF DEATH 1-21-71 13:00 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-07 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 9-13-96 | | 9. AGE (In years last birthday) 74 | | If Under 1 Yr. Months: Oys: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired City Highway Dept. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13. FATHER'S NAME Howard R Jones | | 14. MOTHER'S MAIDEN NAME Luella [REDACTED] Scaraborough | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-09-3786 | | 17. INFORMANT MR. Mr. Raymond L. Jones, 3121 Hiss Avenue | |
| 18. 207X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH submucosal edema (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myeloid Metaplasia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | (B) DUE TO, OR AS A CONSEQUENCE OF: Post-Traumatic Algoria | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-19 19 71 to 1-21 19 71 that (I) (we) last saw the deceased alive on 1-21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE MARIELY NAPIZA M.D. | | | | 23B. DATE SIGNED 1-21-71 | |
| 23C. PHYSICIAN'S NAME (Type) MARIELY NAPIZA M.D. | | 23D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71. | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. [REDACTED] | |
| 25C. FUNERAL DIRECTOR Leonard S. Ruck, Inc. Balto. Md. 21214 | | 25D. ADDRESS | | | |

11-11-11



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0762 | |
|--|---------|--|--------------------------|--|--|
| U-536 71 0762 | | CERTIFICATE OF DEATH X | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | (UNDERWOOD: ROLAND ALBERTUS) | | JAN. 22, 1971 6am | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| | | Maryland, Baltimore | | 53-00 | |
| 44 UNION Memorial Hospital | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 6609 Loch Hill Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| male | white | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9/23/00 | 70 | Pressman |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | USA | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Joseph Underwood | | | Gertrude Lovett | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 578-05-2738A | | Mrs. Myrtha Underwood | |
| | | | | ADDRESS | |
| | | | | (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Acute Myocardial Infarction | | | |
| | | (A) IMMEDIATE CAUSE | | | |
| | | Arterio-sclerotic Cardiovascular Disease | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/21/71 to 1/22/71 that (I) (we) last saw the deceased alive on 1/22/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| H. Earl Cotman, M.D. | | | | 1/22/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| H. Earl Cotman, M.D. | | Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 1/25/71. | | Jessops Methodist Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Cockeysville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 26 1971 | | Leonard G. Ruck, Inc. Balto. Md. 21214 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

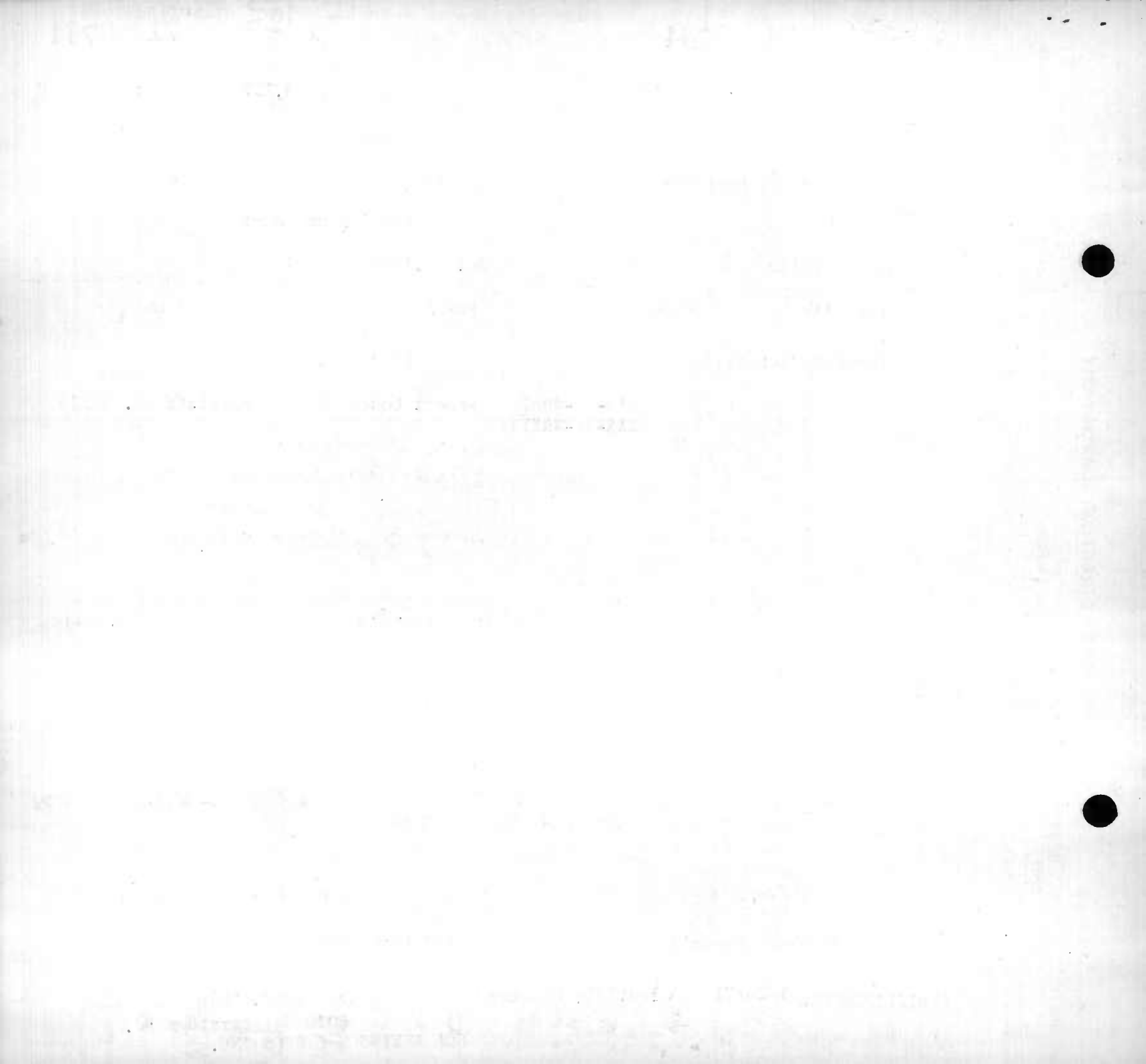
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0763</u> | |
|--|---------------------|--|--|---|--|
| P-265 71 0763 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>EDGAR PICKERING</u> | | 2. DATE AND HOUR OF DEATH <u>1/20/71</u> <u>6:45</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL</u> | | A. STATE <u>MD.</u> | | B. COUNTY <u>9-01</u> | |
| | | C. CITY OR TOWN <u>Balto</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>3905 YOLANDO RD</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/29/11</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>TRANSFER CO.</u> | | 9. AGE in years (lost birthday) <u>59</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>NOBLE PICKERING</u> | | 14. MOTHER'S MAIDEN NAME <u>MARIE BAYRLE</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>215 05 6009</u> | | 17. INFORMANT <u>Mrs Hazel Pickering</u> | |
| | | | | ADDRESS <u>3905 Yolando Rd Balto Md</u> | |
| 18. <u>5-32-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2° TO ASPIRATION</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>PYLORIC OBSTRUCTION</u> <u>DUODENAL ULCER, perforated</u> <u>PERITONITIS 2° ulcer perforation.</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>1/16/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Perforated duodenal ulcer</u> | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 (Month) 24 (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>1/18</u> 19 <u>71</u> to <u>1/20</u> 19 <u>71</u> that (1) last saw the deceased alive on <u>1/20</u> 19 <u>71</u> and that in (my) and opinion death occurred on the date and hour and from the causes stated above. (1) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Karl F. Meek, Jr. M.D.</u> | | | | 23B. DATE SIGNED <u>1/20/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>KARL MECK</u> | | | | 23D. ADDRESS <u>Baltimore, Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-25-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.</u> | | ADDRESS <u>Balto, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

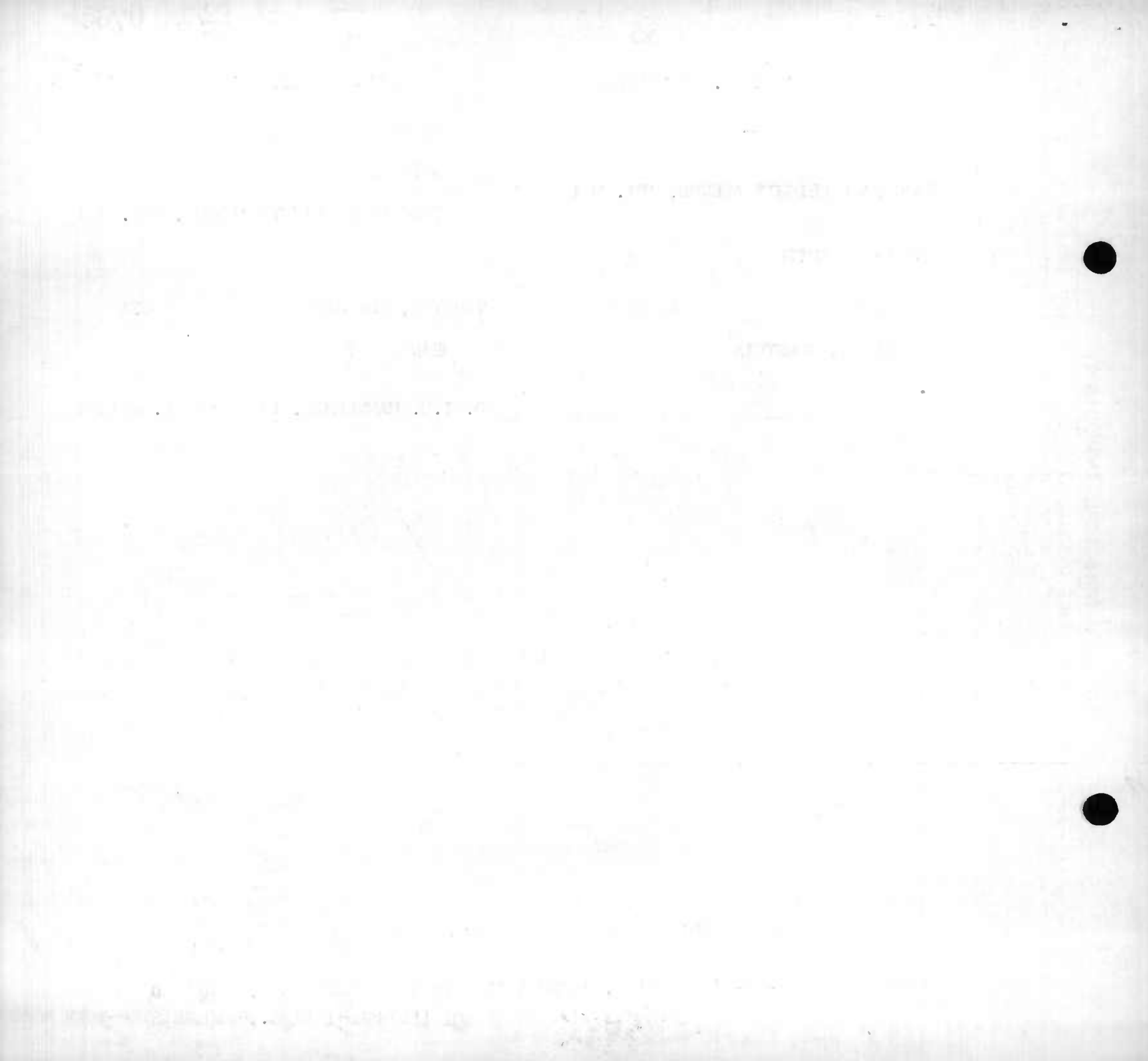
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0764</u> | |
|--|------------------|--|----------------------------------|---|---|
| C-500 71 0764 | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | JENNIE COHEN | | JANUARY 23, 1971 6:16 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL | | MARYLAND Baltimore 53-00 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 42 | | E. STREET AND NUMBER 4 Farrington Court | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 4, 1886 | 9. AGE (In years lost birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Abraham Lebovitz | | 14. MOTHER'S MAIDEN NAME Rifka ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-46-4987 | | 17. INFORMANT Robert Cohen 2905 Fallstaff Rd. 21215 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 19. DATE OF OPERATION 0 | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 19 68 to 23 Jan 19 71, that (I) (we) last saw the deceased alive on December 31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Abraham Genecin MD | | 23B. DATE SIGNED 24 Jan 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) Abraham Genecin | | 23D. ADDRESS 611 Park Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/26/71 | | 24C. NAME of CEMETERY or CREMATORY Glenville Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Cleveland, Ohio | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR R. E. ... | |
| 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. | | 25D. ADDRESS 6010 Reisterstown Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0765 | |
|---|--|---|--|--|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) ESTHER B. HAMMERMAN | | 2. DATE AND HOUR OF DEATH JANUARY 22, 1971 2²⁵ A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7000 PARK HEIGHTS AVENUE, APT. M 1 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7000 PARK HEIGHTS AVENUE, APT. M 1 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 72 | 9. AGE (In years last birthday) 72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) TRENTON, NEW JERSEY | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME RABBI MAX BORSTEIN | | | |
| 14. MOTHER'S MAIDEN NAME IEAH ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 174 X 1 | | 17. INFORMANT MR. I.H. HAMMERMAN, 10 LIGHT ST. #21202 ADDRESS | | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF: Ca of breast (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.H.P. - post coronary. (C) DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="width: 10%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 10 yrs. 5 mo. </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1/21/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to present 19 71 and that (my) (our) opinion death occurred on the date 1/21/71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bernard Burgin M.D. | | 23B. DATE SIGNED 1/22/71 | | 23C. PHYSICIAN'S NAME (Type) BERNARD BURGIN | |
| 23D. ADDRESS 3809 Clarks Lane Balto. 15, Md | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 1-24-71 | | 24C. NAME of CEMETERY or CREMATORY CHIZU, AMUNO (ARLINGTON) | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR SOL LEVINSON | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

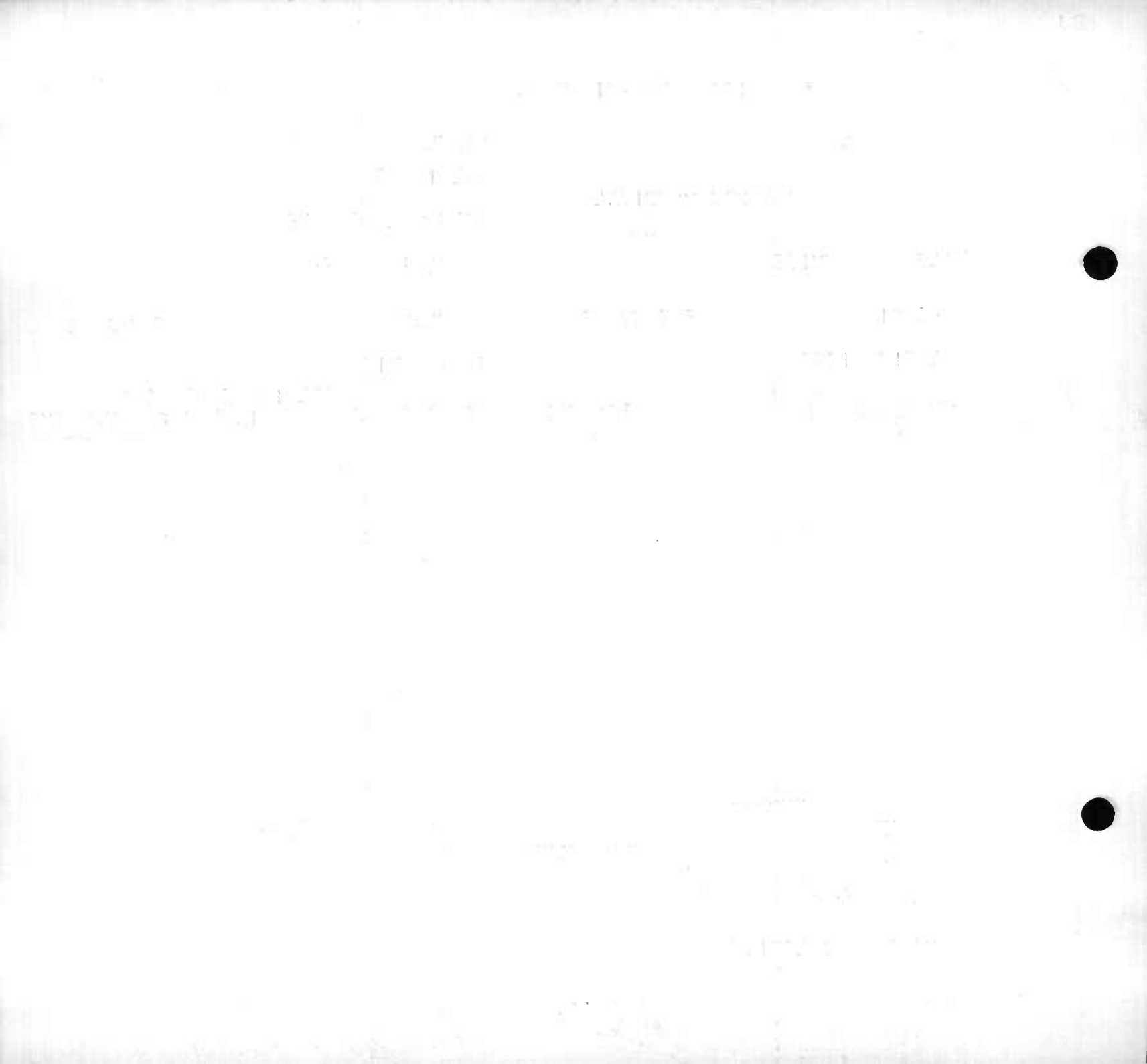
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0766 | | REG. NO. | |
|--|--|--|--|---|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Daniel P. Blair | | January 23, 1971 6 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | Md. | | 6-01 | |
| House in the Pines-Belair Road | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 90 | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Male | | | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH | | | | 9. AGE (In years last birthday) | | 10. If Under 1 Yr. Months Days | |
| Ap. 17, 1895 | | | | 75 | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Salesman | | | | Penn Candy & Tobacco Co. | | Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | U.S. A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William T. Blair | | | | Bertha Marie Zimmerman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | 213-03-1623 | | Mrs. Marie A. Blair - 9 N. Linwood Ave. | |
| 18. 481 X1 | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | 18 hours. | | | |
| ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Acute Lobar Pneumonia | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| II | | | | Artificially Induced Death | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Multiple Small Stroke Death merely stupor years | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15/70 to 1/23/71 that (I) (was) last saw the deceased alive on 1/22/71 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Arthur B. Bradley | | | | 1/25/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | | | 1/26/71 | | New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | | | Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 26 1971 | | | | John A. Moran, Inc. | | 3000 E. Balto., St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. R-200 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0767 | | 71 0767 | |
| 1. NAME OF DECEASED (Type or Print) RIGGS, FRANCIS EDWARD | | | | 2. DATE AND HOUR OF DEATH 1/18/71 4:03 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 40 ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE | | | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR | | 10B. KIND OF BUSINESS OR INDUSTRY DEPT STORE | | 8. DATE OF BIRTH 09 27 10 | | 9. AGE (In years last birthday) 60 | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | |
| 13. FATHER'S NAME FRANCIS RIGGS | | | | 14. MOTHER'S MAIDEN NAME EMMA DAVIS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 215 095472 | | 17. INFORMANT BALTIMORE MD 21229 ST AGNES RECORDS WILKENS & CATON AVES | |
| 18. 4 12 21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive cerebral hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Malignant hypertension CVD | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (X) (X) (X) (X) attended the deceased from 1/18 19 71 to 1/18 19 71 that (I) (X) last saw the deceased alive on 1/18 19 71 and that in (my) (X) (X) (X) (X) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (X) (X) (X) view the body after death. | | | | | | | |
| 23A. SIGNATURE Herbert J. Levickas, MD | | | | 23B. DATE SIGNED 1/18/71 | | 23C. PHYSICIAN'S NAME (Type) HERBERT J. LEVICKAS, MD | |
| 23D. ADDRESS 5404 East Drive | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 1/22/71 | | 24C. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Wm E. Salsbery | | 25C. FUNERAL DIRECTOR Ambrace Inc 1328 Sulphur Sp. Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0768</u> | |
|---|-------------------------|---|------------------------------------|--|--|
| L-652 | | 71 0768 | | X | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>LAWRENCE, MINNIE</u> | | 2. DATE AND HOUR OF DEATH <u>20 JAN 1970</u> <u>1 0630 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN <u>LANDSADOWN</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>MONTEBELLO STATE HOSP.</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91</u> | | E. STREET AND NUMBER <u>2411 BRUNSWICK RD.</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>CAUC.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-24-05</u> | 9. AGE (in years last birthday) <u>65</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Zachariah Thompson Duvall</u> | | 14. MOTHER'S MAIDEN NAME <u>Marian Louisa Ward</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-22-7054 A</u> | | 17. INFORMANT <u>Mr. Robert E. Lawrence, 2411 Brunswick Rd.</u> | |
| 18. <u>309.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Brain Sydrone</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>—</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u> | | <u>1 Year Plus</u> | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u> | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>—</u> | |
| 22. I certify that (we) (this hospital) attended the deceased from <u>28 JULY</u> 19 <u>70</u> to <u>20 JAN</u> 19 <u>70</u> that (we) last saw the deceased alive on <u>20 JAN</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Bruce A. Mallin, M.D.</u> | | 23B. DATE SIGNED <u>20 JAN 71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>BRUCE A. MALLIN, M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-23-1971</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Woodfield Church Cemetery</u> | |
| 24D. LOCATION <u>Montgomery County, Maryland</u> | | 24E. ADDRESS <u>4107 WILKENS AVE.</u> | | 24F. ADDRESS <u>—</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Lawrence</u> | | 25C. FUNERAL DIRECTOR <u>—</u> | |

Burial

1-23-1971 Woodfield Church Cemetery Montgomery County, Maryland

Yes

Chronic Brain Syndrome 1 Year Plus

Pulmonary Embolism Minutes

Mr. Robert E. Lawrence, 2411 Brunswick Rd.

21227

Marian Louise Ward

Maryland

Zachariah Thompson Duval

XXXXXXXXXXXXXXXXXXXX

No

D.O.A. RELEASED TO HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| P-100 71 0769 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0769 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) John N. Popp | | 2. DATE AND HOUR OF DEATH January 21, 1971 10:39 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 14940 Eastern Avenue Baltimore, Maryland 21224 | | C. CITY OR TOWN ESSEX | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 357 Oberle Avenue 21221 | | 5. SEX Male | | 6. RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-3-00 | | 9. AGE (in years last birthday) 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE A. POPP | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) VNA | | 16. SOCIAL SECURITY NO. 213-01-2947 A | | 17. (INFORMANT BCH: Records 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Aortic Insufficiency + Stenosis | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Probable fatal cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF: can't R/O MI (B) ASCVD + LVH, LBBB, CHF DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate years years | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from Jan 19 69 to 1/21/71 that (1) (we) last saw the deceased alive on 1/11/71 19 71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE S. W. Douglas III M.D. DEGREE | |
| 23B. DATE SIGNED 1/21/71 | | 23C. PHYSICIAN'S NAME (Type) S. W. Douglas III M.D. DEGREE | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/25/71 | | 24C. NAME of CEMETERY or CREMATORY OAK LAWN | |
| 24D. LOCATION BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 25 1971 | | 25B. NAME OF REGISTRAR J. D. CONNELLY | |
| 25C. FUNERAL DIRECTOR J. D. CONNELLY | | 25D. ADDRESS 300 MACE | | | |

Handwritten text, possibly a date or reference number.

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VS 151-REV. 7/1/68

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0770

GAIDFELT & SONS

MADE IN U.S.A.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0771 | |
|--|--|--|--|---|--|
| K-614 71 0771 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) KREIPL, KATHRYN M. (Mrs. Louis) | | 2. DATE AND HOUR OF DEATH 1. 21. 71 12.25A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 UNION MEMORIAL HOSPITAL. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-43 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL. | | C. CITY OR TOWN BALTIMORE. | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female | | 6. RACE WHITE. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 11. 29. 13. | | 9. AGE (In years last birthday) 57. | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector. | | 10B. KIND OF BUSINESS OR INDUSTRY General Elevator Co. 601 Nursery Rd., Lenthicum. | | 11. BIRTHPLACE (State or foreign country) MARYLAND. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME CLARENCE MYERS | | 14. MOTHER'S MAIDEN NAME MARY WEAVER. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-03-8209 | | 17. INFORMANT MR. LOUIS KREIPL | |
| 18. 410.9 I CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Cardio pulm. Arrest. DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) Ascend E acute MI. DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) 40 Peptic ulcer, 40 U Bladder Tumor | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 1. 25. 71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1. 15. 71 19 to 1. 21. 1971 that (I) (we) last saw the deceased alive on 1. 21. 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Mahmood Ali Khan | | | | 23B. DATE SIGNED 1. 21. 71. | |
| 23C. PHYSICIAN'S NAME (Type) MAHMOOD ALI KHAN MD | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 1-25-71 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Brehms Lane & Mammata Ave. | | | |



R-400

71 0772

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0772

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) CHARLES E. REELY | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4249 Shamrock Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 22 1971 9:15 a M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 2/2/1916 | | 10. AGE (In years lost birthday) 54 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Charles R. Reely | | 14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 26-42 | |
| 15. MOTHER'S MAIDEN NAME Florence Keeney | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 17. SOCIAL SECURITY NO. 218-01-8412 | | 18. INFORMANT Dorothy Meison Reely, wife, above | |
| 19. CAUSE OF DEATH 485X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (APPROX.) Month Day Year Hour 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. M.D. DATE SIGNED 1-22-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Ivy Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Laurel, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Chas. E. Reely | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | 25D. ADDRESS 3331 Brehms Lane | |

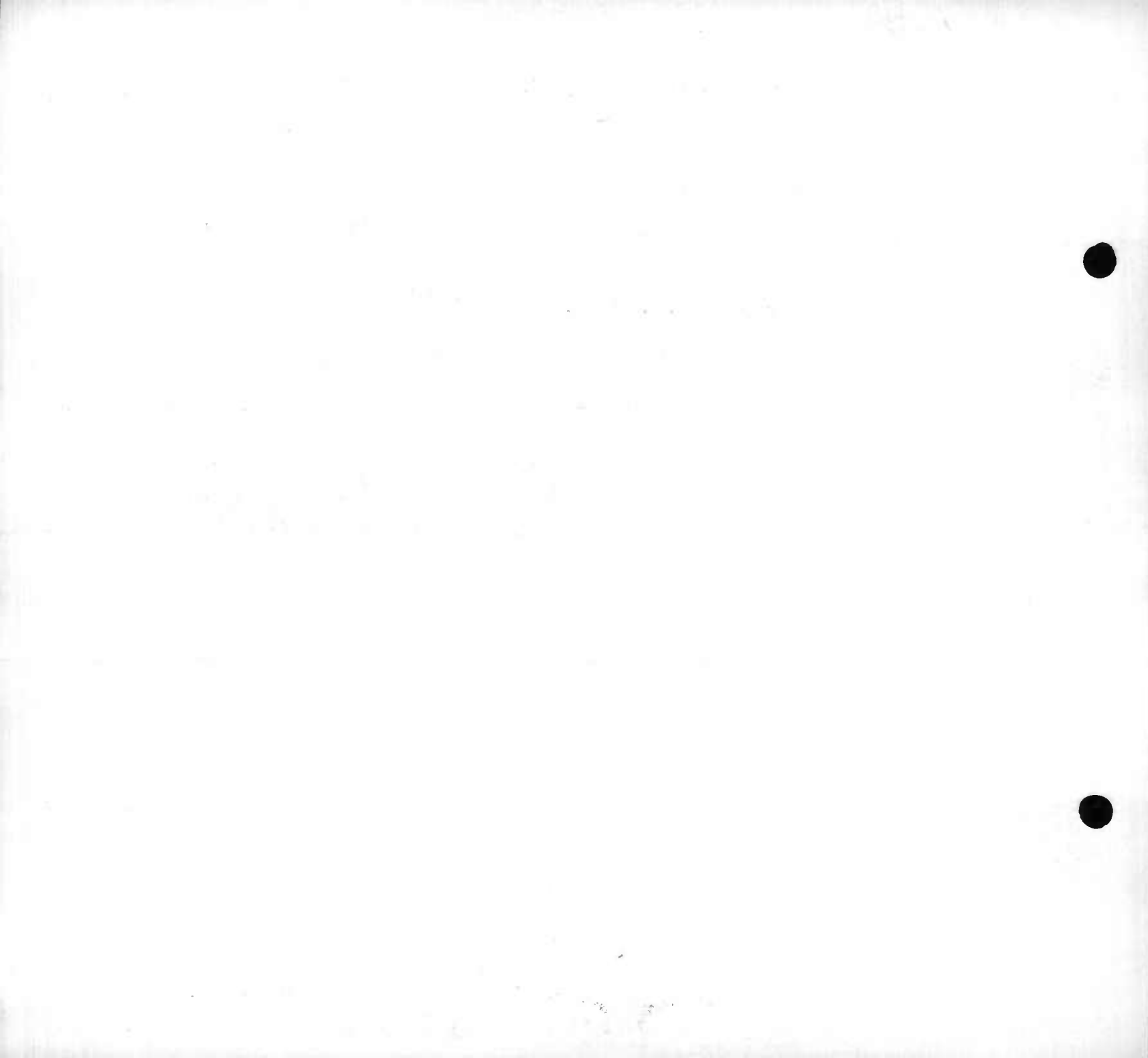
2/26/71 - Letter from M.E.O.

Age

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

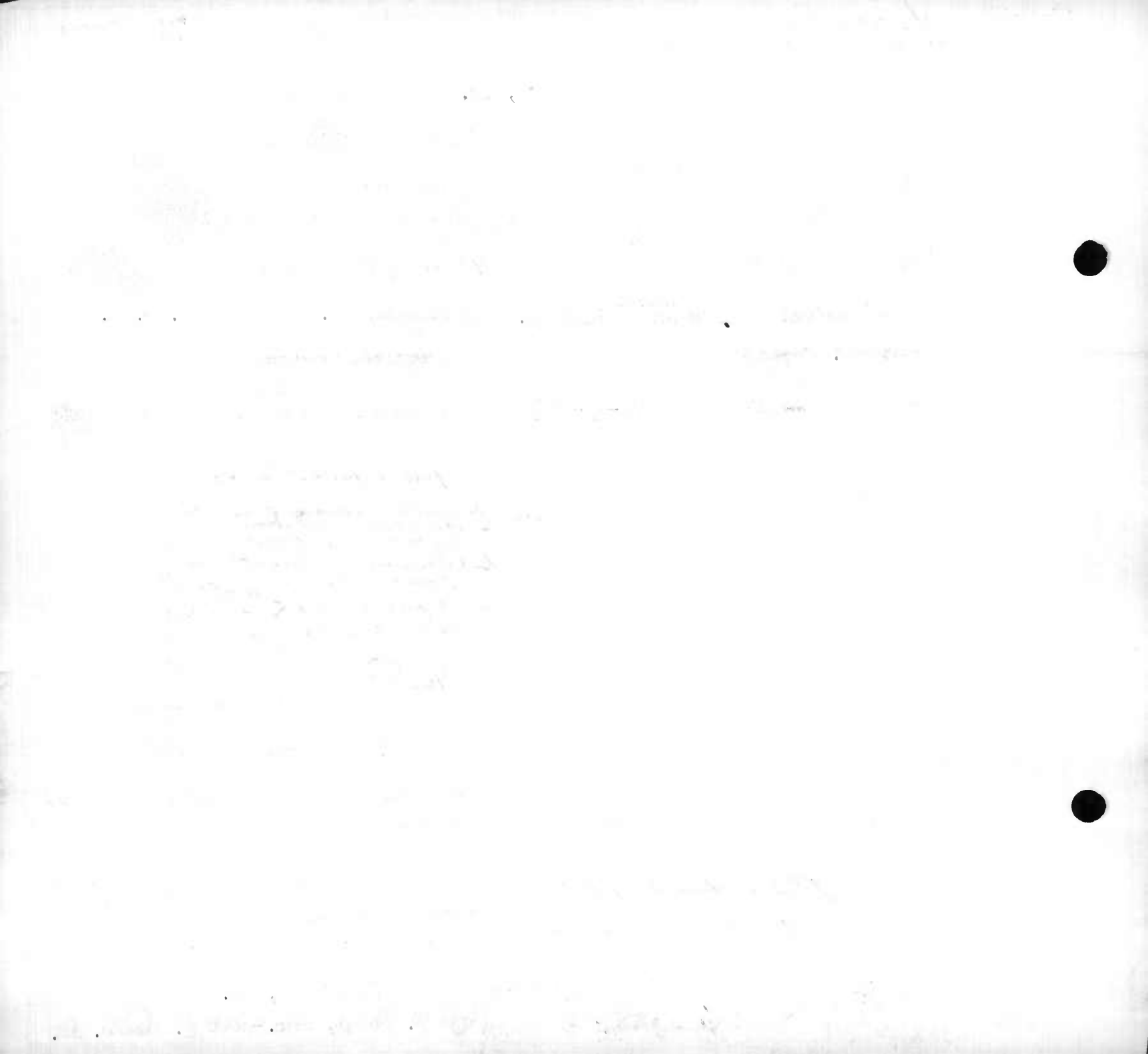
| | | | | | |
|---|------------------|---|---|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 0773 | | 71 0773 | |
| BIRTH NO. B525 | | CERTIFICATE OF DEATH | | REG. NO. 71 0773 | |
| 1. NAME OF DECEASED (Type or Print) Bonsignore, Lois Beth | | | 2. DATE AND HOUR OF DEATH JAN 22, 1971 1:35 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University of Md. Hosp. | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 504 Carrollwood Road, 21220 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-8-31 | 9. AGE (In years last birthday) 39 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10B. KIND OF BUSINESS OR INDUSTRY H.C.A. Corp. | | 11. BIRTHPLACE (State or foreign country) Oakland Md. | |
| 13. FATHER'S NAME Pedar Baasland | | | 14. MOTHER'S MAIDEN NAME Gertrude DeWitt | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-32-4200 | | 17. INFORMANT ADDRESS Mariano Bonsignore, husband, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma to Bone ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Narrow, B pleural cavity, C lymphatic spread D Lung | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 6 wks. | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 1-22-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-5 19 71 to 1-22 19 71 that (I) (we) last saw the deceased alive on 1-22 19 71 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. Jae Ihm MD | | | | 23B. DATE SIGNED 1-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) H. Jae Ihm MD | | 23D. ADDRESS Univ of Md Hospital - Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | | |
| 25B. NAME OF REGISTRAR Chloe J. [illegible] | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home Inc. | | | |
| 25D. ADDRESS 8331 Brehms Lane | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 0774 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0774 | |
|---|-------------------------|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) <u>Hughes, Andrew J., Sr.</u> | | | 2. DATE AND HOUR OF DEATH <u>1-22-71</u> <u>8:15</u> AM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave</u> <u>Baltimore, Md 21224</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | |
| | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>924 Lance Avenue</u> <u>21221</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-21-14</u> | 9. AGE (In years last birthday) <u>56</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Anchor Motor Freight Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>Andrew J. Hughes</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Margaret Leyphon</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u> | | | |
| 16. SOCIAL SECURITY NO. <u>276-03-9463</u> | | 17. INFORMANT ADDRESS <u>BCH: Records Baltimore, Maryland 21224</u> | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>prob. infected wound</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>1) general debility due to Alcoholism chronic - Cirrhosis of liver</u> <u>had chronic abscess over</u> <u>umbilicus</u></p> <p>(C) <u>Septicemia & fungal</u> <u>severe pressure sores</u></p> </div> </div> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? Yes or No <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/27/70</u> 19 <u>70</u> to <u>1/22/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/22/71</u> at <u>8:15</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>P. S. Eshachary MD</u> | | | | 23B. DATE SIGNED <u>1/22/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>P S ESHACHARY</u> | | | | 23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/25/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>John A. Moran</u> | | 25C. FUNERAL DIRECTOR <u>John A. Moran, Inc. - 3000 E. Balto. St.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------|--|---------------------------------------|
| <div style="display: flex; justify-content: space-between;"> S-262 71 0725 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH REG. NO. 71 0725 </div> | | | |
| 1. NAME OF DECEASED (Type or Print) Eunice E. Siekierski | | 2. DATE AND HOUR OF DEATH 1/21/71 9:40 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital | | A. STATE B. COUNTY Maryland Baltimore | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore 21220 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 49 713 Wampler Road | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/18/06 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | 10B. KIND OF BUSINESS OR INDUSTRY Leather Product Co. | 9. AGE (In years last birthday) 64 |
| 11. BIRTHPLACE (State or foreign country) Delto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Greenbury Sevier | | 14. MOTHER'S MAIDEN NAME Rosa Johnson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-07 4891 | |
| 17. INFORMANT John Siekierski | | ADDRESS Same | |
| 18. 582X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Uremia DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension | |
| 19. DATE OF OPERATION | | 20. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/13 to 1/21 19 71 that (I) (we) last saw the deceased alive on 1/21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Joe Maritner | | 23B. DATE SIGNED 1/21/71 | |
| 23C. PHYSICIAN'S NAME (Type) JOE MARITNER | | 23D. ADDRESS Medical Arts Bldg 21201 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | |
| 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home | | ADDRESS 1407 Eastern Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|--|--|---|--|
| A-654 71 0776 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0776 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MRS. Betty Arnold | | 2. DATE AND HOUR OF DEATH 1-23-71 4:45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore | | 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION MELCHOR NURSING HOME 2327 N. CHARLES ST. BALTIMORE, Md. 21218 | | C. CITY OR TOWN Essex 21221 | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 1614 Doolittle Rd. Apt-B | | 5. SEX Female | | 6. RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 9-24-22 | | 9. AGE (In years lost birthday) 48 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY General Offices | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME ORION SEARS | | 14. MOTHER'S MAIDEN NAME Ida P DEHRING | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213 28 4474 | | 17. INFORMANT ADDRESS Susan B. Zinkhan 12 National Dr. Balto 21220 | |
| 18. 170.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) metastatic chondrosarcoma | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic chondrosarcoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from October 15 1970 to January 19 71 , that (I) (we) last saw the deceased alive on January 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE A. Allan Smith | | 23B. DATE SIGNED 1-23-71 | | 23C. PHYSICIAN'S NAME (Type) Dr. Allan Smith | |
| 23D. ADDRESS Bruzdinski Funeral Home 1407 Eastern Ave. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/27/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | |
| 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Bruzdinski Funeral Home | | 25D. ADDRESS 1407 Eastern Ave. | |

1933

Class Secretary General Office

213 28 400 Susan P. Eakin is National Dr. 1933

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-400 71 0777 | | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0777 | |
|---|-------------------------|---|--|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) BUCK BAILEY | | | | 2. DATE AND HOUR OF DEATH 01-23-71 12:15 midn. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE VIRGINIA B. COUNTY V-43 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | | | C. CITY OR TOWN WOODBIDGE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| ADDRESS OR LOCATION BALTIMORE, MD 21205 | | | | E. STREET AND NUMBER 1413 F STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 02-28-08 | | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Officer | | | 10B. KIND OF BUSINESS OR INDUSTRY Electronic | | 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JOHN Bailey | | | | 14. MOTHER'S MAIDEN NAME Margaret Buck Timms | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11 | | 16. SOCIAL SECURITY NO. 578 16 9801 | | 17. INFORMANT Helen H. Bailey, Woodbridge, Va. | | ADDRESS 22191 | |
| 18. 472.4 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) cardiac arrhythmia? ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 2/4/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ventricular aneurysm | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-13-70 19 to 1-23-71 19, that (I) (we) last saw the deceased alive on Jan 23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Steven R. Austin, M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/23/71 | |
| 23C. PHYSICIAN'S NAME (Type) STEVEN R. AUSTIN, MD | | | | 23D. ADDRESS 550 N. Broadway | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 26 Jan. 71 | | 24C. NAME OF CEMETERY or CREMATORY Sunset Memorial Gardens | | 24D. LOCATION (City, town, or county) (State) Fredericksburg, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Wm. J. Taylor | | 25C. FUNERAL DIRECTOR Cunningham-MountcastleFunwralHome | | | |

11-15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|---|---|--|--|
| BIRTH NO. <u>M-265</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71 0778</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Charlotte B. McCormick</u> | | | 2. DATE AND HOUR OF DEATH <u>1/25/71</u> <u>1:40</u> P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1-26-71</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>53-00</u> | | |
| 5. SEX <u>F</u> | | | 6. RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>1889</u> <u>7-7-1889</u> |
| 13. FATHER'S NAME <u>Philip</u> | | | 14. MOTHER'S MAIDEN NAME <u>Frick</u> | | 9. AGE (In years last birthday) <u>81</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>218-01-8878</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 17. INFORMANT <u>Norvin C. McCormick</u> | | | ADDRESS <u>107 Holly</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> |
| 18. <u>575X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> (B) <u>Stress ulcer, massive g.i. bleeding</u> (C) <u>Gangrene of gall bladder</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> <u>5 days</u> <u>14 days</u> |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hiatal hernia, Diverticulosis sigmoid.</u> | | | | | |
| 19A. DATE OF OPERATION <u>11-11-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fair</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-29-70</u> to <u>1-25-71</u> that (I) (we) last saw the deceased alive on <u>1-25-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>P.C. Kahle M.D.</u> | | | | 23B. DATE SIGNED <u>1-25-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>P. CHOTIKUL KAHLE</u> | | | | 23D. ADDRESS <u>BON SECOURS HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/28/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR, ADDRESS <u>Witzke, Inc. 1630 Edmondson Ave. 21228</u> | | 25D. NAME OF REGISTRAR <u>0000</u> | |

V.S. 153

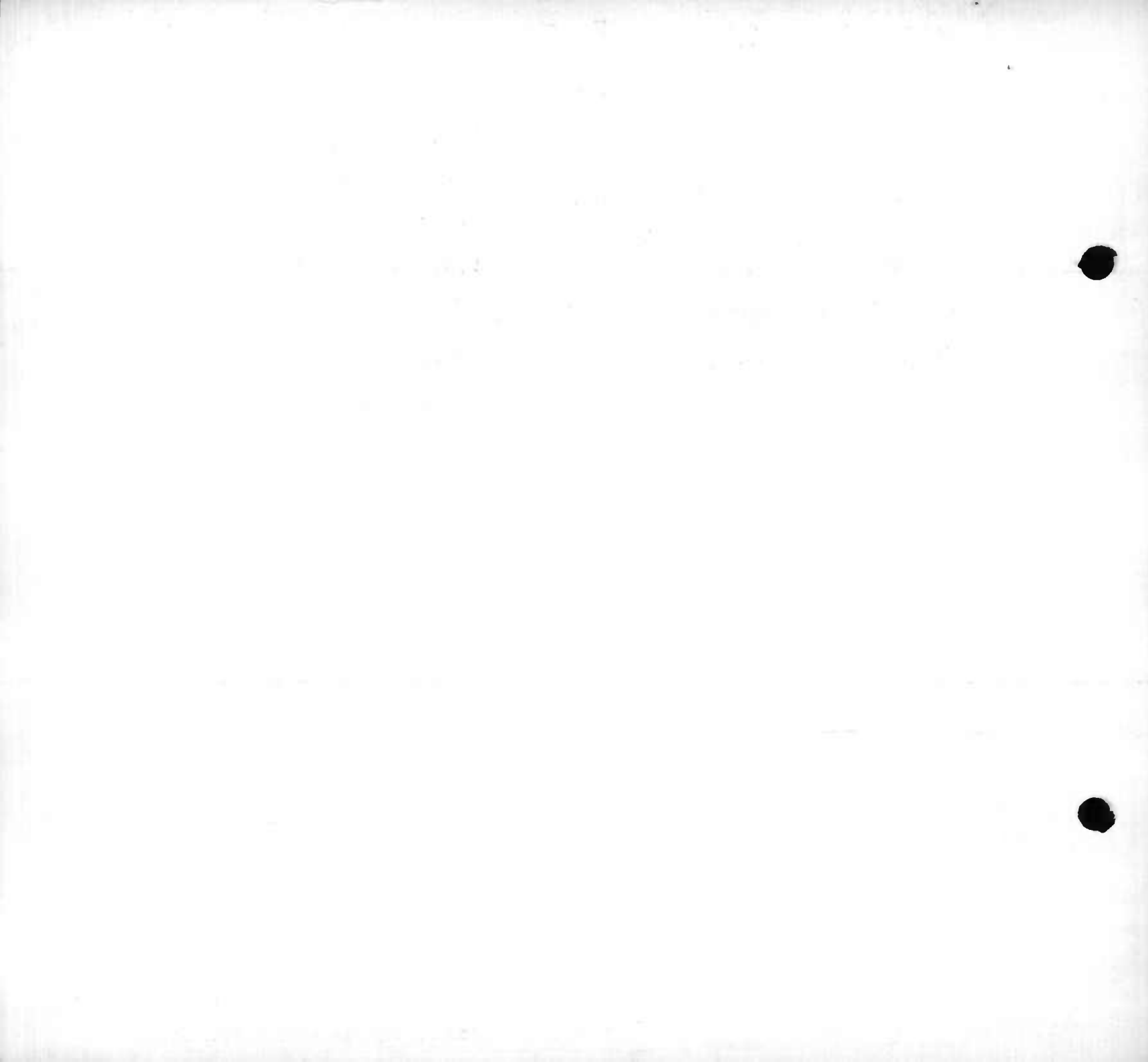
1-26-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|---|-------------------------------------|---|-----------------------|---|-----------------------|
| D-600 | | 71 0779 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0779 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mr. Joseph M. Duerr</u> | | 2. DATE AND HOUR OF DEATH <u>Jan. 22, 1971</u> <u>12:05 P.M.</u> | | REG. NO. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secours Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u> | | | | C. CITY OR TOWN <u>Ehlicott City</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>9221 W. Stayman Dr.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>08/20/23</u> | 9. AGE (In years last birthday) <u>47</u> | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cep Telephone Co.</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Administrative Asst.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | | | | | | |
| 13. FATHER'S NAME <u>Valentine Duerr</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Kroeger</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> | | | | 16. SOCIAL SECURITY NO. <u>218-10-0111</u> | | 17. INFORMANT <u>Mrs. Dorothy Duerr</u> | |
| | | | | ADDRESS <u>Same</u> | | | |
| 18. <u>203 X I</u> CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Pulmonary embolism</u> <u>1 hour</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>Cardiac arrest due to Acute massive myocardial infarction.</u> <u>1 hour</u> | | | |
| | | | | (C) <u>Multiple Myeloma.</u> <u>2 years</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January, 5</u> 19 <u>71</u> to <u>January, 22</u> 19 <u>71</u> , that (I) (we) lost saw the deceased alive on <u>January, 22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Chum Sae Pruk Sapong, M.D.</u> | | | | 23B. DATE SIGNED <u>January, 22, 1971.</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>CHUM SAE PRUK SAPONG, M.D.</u> | | | | 23D. ADDRESS <u>Bon Secours Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/25/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Crestlawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Marriottsville, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Reed J. ...</u> | | 25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0780 | |
|---|-----------|--|---|--|--------------------------------|
| V-400 71 0780 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Joseph F. Voll | | 1-24-71 10:45A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE, MARYLAND 21229 | | | A. STATE 20-37 | | |
| | | | B. COUNTY | | |
| | | | C. CITY OR TOWN | | |
| | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER | | |
| | | | 421 Lyndhurst Street | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Male | Caucasian | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12-12-08 | 72 | 11. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired Auditor | | U.S. Gov't | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| George J | | | Mary E. Combs | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Mrs. Marguerite Voll 421 Lyndhurst St. | |
| 18. 162.1 I CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | | Acute Respiratory failure | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Recurrent C. & bronchitis | | |
| | | | (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | C. of Lung | | YES | |
| 21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 1 24 71 | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-24-1971 to 1-24-1971 that (I) (we) last saw the deceased alive on 1-24-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| P. Sabanayagam | | | 1/24/71 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| P. Sabanayagam | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 1/27/71 | | Crestlawn | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Maryland 21229 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 26 1971 | | P. Sabanayagam | | Witzke's Inc. | |
| | | | | ADDRESS 21228 1630 Edmondson Ave. | |

Date of operation — not known but not recent

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71 0781 BALTIMORE CITY HEALTH DEPARTMENT

M-320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 0781

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Gregory Mathews | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 24 Year 71 Hour 1:55 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 John Hopkins Hospital | | 3. DATE PRONOUNCED DEAD Month 1 Day 24 Year 71 Hour 1:55 p.m. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1/16/54 | | 10. AGE (In years) 17 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 13. FATHER'S NAME Arthur Davis | | 15. MOTHER'S MAIDEN NAME Pauline Jain | |
| 18. INFORMANT Pauline Jain | | ADDRESS 1035 Hillman St. | |
| 19. E 765 X | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Gunshot wound of neck | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET | |
| 22D. TIME OF INJURY (APPROX.) 1 16 71 1:55 a.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 800 blk. N. Central | | 22F. HOW DID INJURY OCCUR? Subject was shot by unknown assailant. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 1/25/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pl. | | 24D. LOCATION (City, town, or county) (State) Arbutus Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Jones | |
| 25C. FUNERAL DIRECTOR Joseph J. Lock | | ADDRESS 1304 N. Central | |

VS 151-REV. 1/1/68

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0782

BIRTH NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) GEORGE W. CANAPP | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 24, 1971 12:15 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION 44 Union Memorial Hospital University Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 24, 1971 12:15 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-48 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH March 12, 1908 | | 10. AGE (in years last birthday) 62 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 218-10-4172 | |
| 15. MOTHER'S MAIDEN NAME ? Craig | | 18. INFORMANT Catherine Canapp - 1518 Cox St. | |
| 19. 412.2 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 24, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/27/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR 0782 | |
| 25C. FUNERAL DIRECTOR Donovan Funeral Home | | ADDRESS -3818 Roland Ave. | |

TO THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

FROM THE CHIEF OF THE BUREAU OF THE ARMY
WASHINGTON, D. C.

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

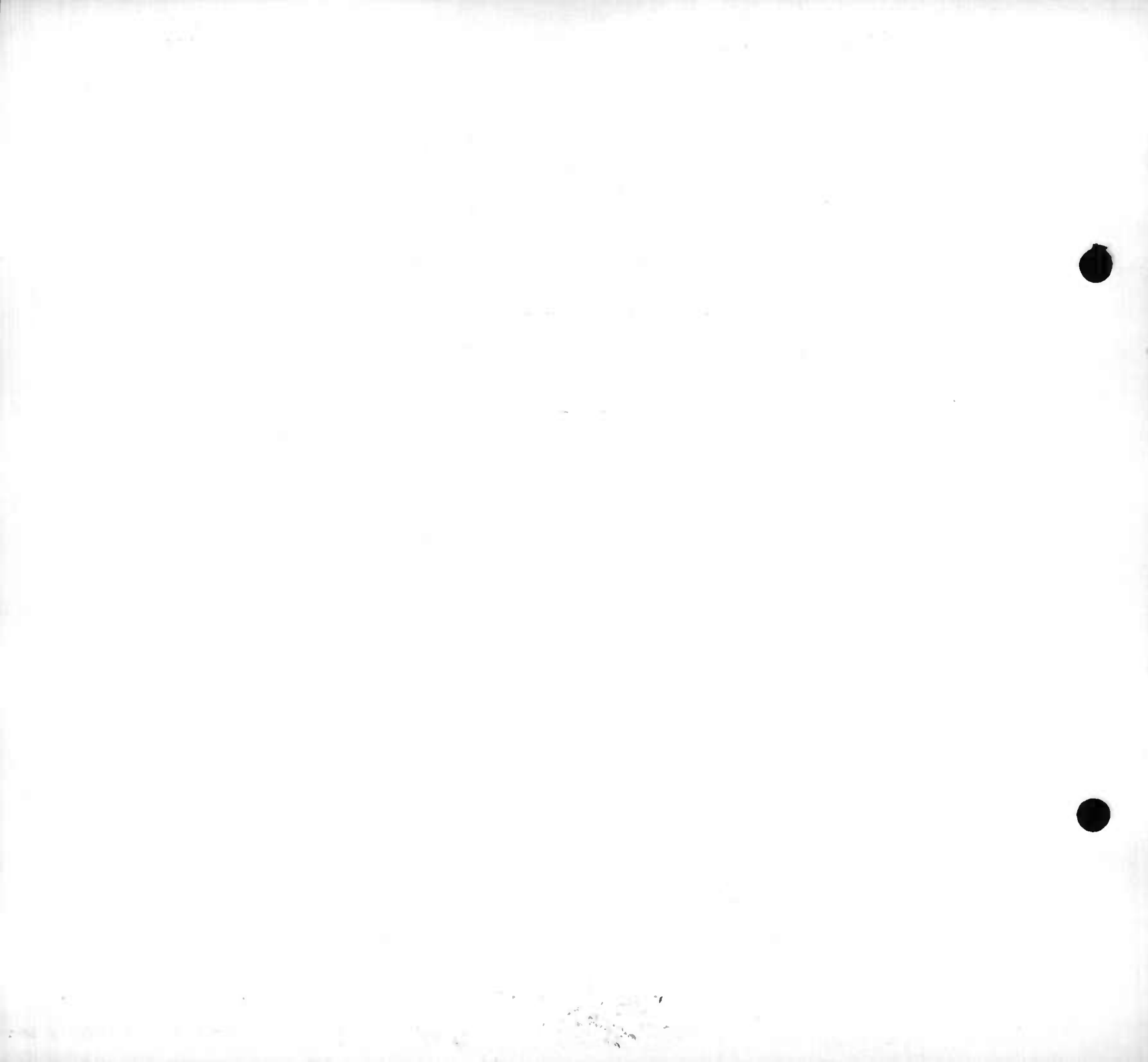
7. [Illegible]

8. [Illegible]

9. [Illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0783 | |
|--|---|---|---|---|---|
| 71 0783 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. H-240 | | 1. NAME OF DECEASED (Type or Print) MARY C. HACKLEY | | 2. DATE AND HOUR OF DEATH 1-24-71 7 45 <small>M.</small> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 13-06 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital 33rd + Calvert St. | | | C. CITY OR TOWN Baltimore City | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 3323 Beech Ave. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 08-10-24 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13. FATHER'S NAME John Brown | | 14. MOTHER'S MAIDEN NAME Clemintine Hesson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212-44-1188 | | 17. INFORMANT Paul Hackley ADDRESS 3345 Reswick Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) renal insufficiency Cardiac failure | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ca 4-5 mo. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: right sided nephrectomy due to CA 15 yrs ago. | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 1/24 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 1/15 19 71 to 1/24 19 71 that (1) (we) last saw the deceased alive on 1/24 19 71 and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles Fizekas M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Charles Fizekas M.D. | | | | 23D. ADDRESS Union Memorial Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | | 24C. NAME of CEMETERY or CREMATORY St. Mary's Cem.-Hampden | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Donovan | |
| 25C. FUNERAL DIRECTOR Donovan | | ADDRESS Funeral Home - 3818 Roland Ave. | | | |



H-535 71 0784 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. *71 0784*

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) James Hinton | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 18 71 7:40 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 71 7:40 a. M. | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 16-05 | |
| 6. SEX male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8-27-53 | | 10. AGE (In years last birthday) 17 | | E. STREET AND NUMBER 847 N. Bentalou St. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Emerson Hinton | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Lucy Parker | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Lucy Hinton-847 N. Bentlow Street | |
| 19. 421.0 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | Subacute bacterial endocarditis | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) NO | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Sty Hinton</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/22/70 | | 24C. NAME OF CEMETERY or CREMATORY mt Calvary | |
| 24D. LOCATION (City, town, or county) (State) to a Co. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Special of Sora V. in Monty | | 25D. ADDRESS 122 | | | |

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ACADEMIC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. [REDACTED] |
|---|---------------------|--|-------------------------------------|---|
| G-650 | | 71 0785 | 71 0785 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Green Nelson</u> | | 2. DATE AND HOUR OF DEATH <u>3:00 PM 1-10-71</u> M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing CC</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>23-01</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>111 W Henrietta St</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/19/71</u> | 9. AGE (In years last birthday) <u>71</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tug Boat</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Va.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>unk.</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Holly Christian</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. <u>227-18-4796</u> | | 17. INFORMANT <u>Mrs Mabel C. Brown</u> | | |
| 18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CA of Lung Terminal</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16-22-70</u> |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u> | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>—</u> |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-8</u> 19 <u>71</u> to <u>1-10</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1-10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>A. Mamasif, Jr.</u> | | 23B. DATE SIGNED <u>1-11-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Burial</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/16/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>McGowan</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Balt City</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Poland Brown</u> | | |
| 25D. ADDRESS | | 25E. ADDRESS | | |



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M-23071

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0786

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Michael E. McQuaid | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5013 Park Heights Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 71 7:35 p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH June 13, 1900 | | 10. AGE (in years last birthday) 70 | |
| 11. BIRTHPLACE (State or foreign country) Prince Edward Island, Canada | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas McQuaid | | 14. MOTHER'S MAIDEN NAME Mary Ann Kelly | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist | | 16. KIND OF BUSINESS OR INDUSTRY - - - | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) NO | | 18. SOCIAL SECURITY NO. 214 38 9757 | |
| 19. 412.4 I | | 20. INFORMANT ADDRESS Mr. Wilfred T. McQuaid 403 Alleghany Avenue | |
| 21. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| 23. MEDICAL CERTIFICATION I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | 24. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 1/19/71 | |
| 25. DATE OF OPERATION 0 | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 31. DATE OF OPERATION 0 | | 32. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 33. DATE OF OPERATION 0 | | 34. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 35. DATE OF OPERATION 0 | | 36. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 37. DATE OF OPERATION 0 | | 38. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 39. DATE OF OPERATION 0 | | 40. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 41. DATE OF OPERATION 0 | | 42. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 43. DATE OF OPERATION 0 | | 44. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 45. DATE OF OPERATION 0 | | 46. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 47. DATE OF OPERATION 0 | | 48. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
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| 51. DATE OF OPERATION 0 | | 52. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 53. DATE OF OPERATION 0 | | 54. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 55. DATE OF OPERATION 0 | | 56. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 57. DATE OF OPERATION 0 | | 58. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 59. DATE OF OPERATION 0 | | 60. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 61. DATE OF OPERATION 0 | | 62. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 63. DATE OF OPERATION 0 | | 64. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 65. DATE OF OPERATION 0 | | 66. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 67. DATE OF OPERATION 0 | | 68. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 69. DATE OF OPERATION 0 | | 70. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 71. DATE OF OPERATION 0 | | 72. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 73. DATE OF OPERATION 0 | | 74. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 75. DATE OF OPERATION 0 | | 76. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 77. DATE OF OPERATION 0 | | 78. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 79. DATE OF OPERATION 0 | | 80. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 81. DATE OF OPERATION 0 | | 82. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 83. DATE OF OPERATION 0 | | 84. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 85. DATE OF OPERATION 0 | | 86. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 87. DATE OF OPERATION 0 | | 88. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 89. DATE OF OPERATION 0 | | 90. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 91. DATE OF OPERATION 0 | | 92. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 93. DATE OF OPERATION 0 | | 94. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 95. DATE OF OPERATION 0 | | 96. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 97. DATE OF OPERATION 0 | | 98. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 99. DATE OF OPERATION 0 | | 100. CONDITION FOR WHICH OPERATION WAS PERFORMED | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 0782 | |
|---|----------------------|--|-------------------------------------|---|--|--|-----------------------|
| BIRTH NO. D-120 | | | | NAME OF DECEASED 71 0782 DAVIS, RASCOE | | DATE AND HOUR OF DEATH 1-23-71 6 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL | | | | A. STATE MARYLAND | | B. COUNTY CARROLL 56-00 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN UNION BRIDGE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER RURAL | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAR 13-1904 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWN FARM | | 10B. KIND OF BUSINESS OR INDUSTRY FARMER | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME BESSIE DAVIS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) NO | | 16. SOCIAL SECURITY NO. 219-20-4235 | | 17. INFORMANT DORIS E MOORE 1621 E 30th ST. Baltimore, MD | | | |
| 18. 482.3 I CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure 13 days | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (B) Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (C) Staphylococcus pneumonia | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Cardiac arrhythmia, pyelonephritis | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Carroll county | | | |
| 21D. TIME OF INJURY (APPROX) 1-11-71 5 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Spontaneous | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-11 19 71 to 1-23 19 71 that (I) (we) last saw the deceased alive on 1-23 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE P. Boonswang, M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-23-71 | |
| 23C. PHYSICIAN'S NAME (Type) DR. PRICHA BOONSWANG | | | | 23D. ADDRESS UNIVERSITY HOSPITAL BALTIMORE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE JAN 27-1971 | | 24C. NAME OF CEMETERY OR CREMATORY MT JOY | | 24D. LOCATION (City, town, or county) (State) UNIONTOWN MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Sabers | | 25C. FUNERAL DIRECTOR D. D. Hartzler & Sons Union Bridge | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>71 0788</u> | |
|--|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>ETHEL MARY SHEPPARD</u> | | 2. DATE AND HOUR OF DEATH <u>1-22-71</u> <u>8:00</u> PM. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GENERAL HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>11-02</u> | | | |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>DIVORCED</u> | | 8. DATE OF BIRTH <u>5-17-05</u> 9. AGE (In years last birthday) <u>65</u> | | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (State or foreign country) <u>SO. AMERICA</u> | |
| 13. FATHER'S NAME <u>? STALLARD</u> | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-14-2098</u> | | 17. INFORMANT <u>RICHARD W. SHEPPARD</u> ADDRESS <u>BROTHER - IN-LAW</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>42.4</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>POSSIBLE MYOINFARCTION</u> | | CAUSE OF DEATH (A) <u>Pulmonary Edema, massive</u> DUE TO <u>EMBOLE</u> <u>massive</u> (B) <u>and/or Myocardial INFARCTION</u> DUE TO (C) <u>AGE V.D.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>2 None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> 19 <u>71</u> to <u>1-22</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>1-22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>William O. Quisenberry</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>1-22-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>WILLIAM O. QUISENBERRY</u> | | 23D. ADDRESS <u>MARYLAND GENERAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 24B. DATE <u>1/26/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>LEE FUNERAL HOME WASH. D.C.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Edgar M. Mable</u> ADDRESS <u>311 Frederick Rd</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

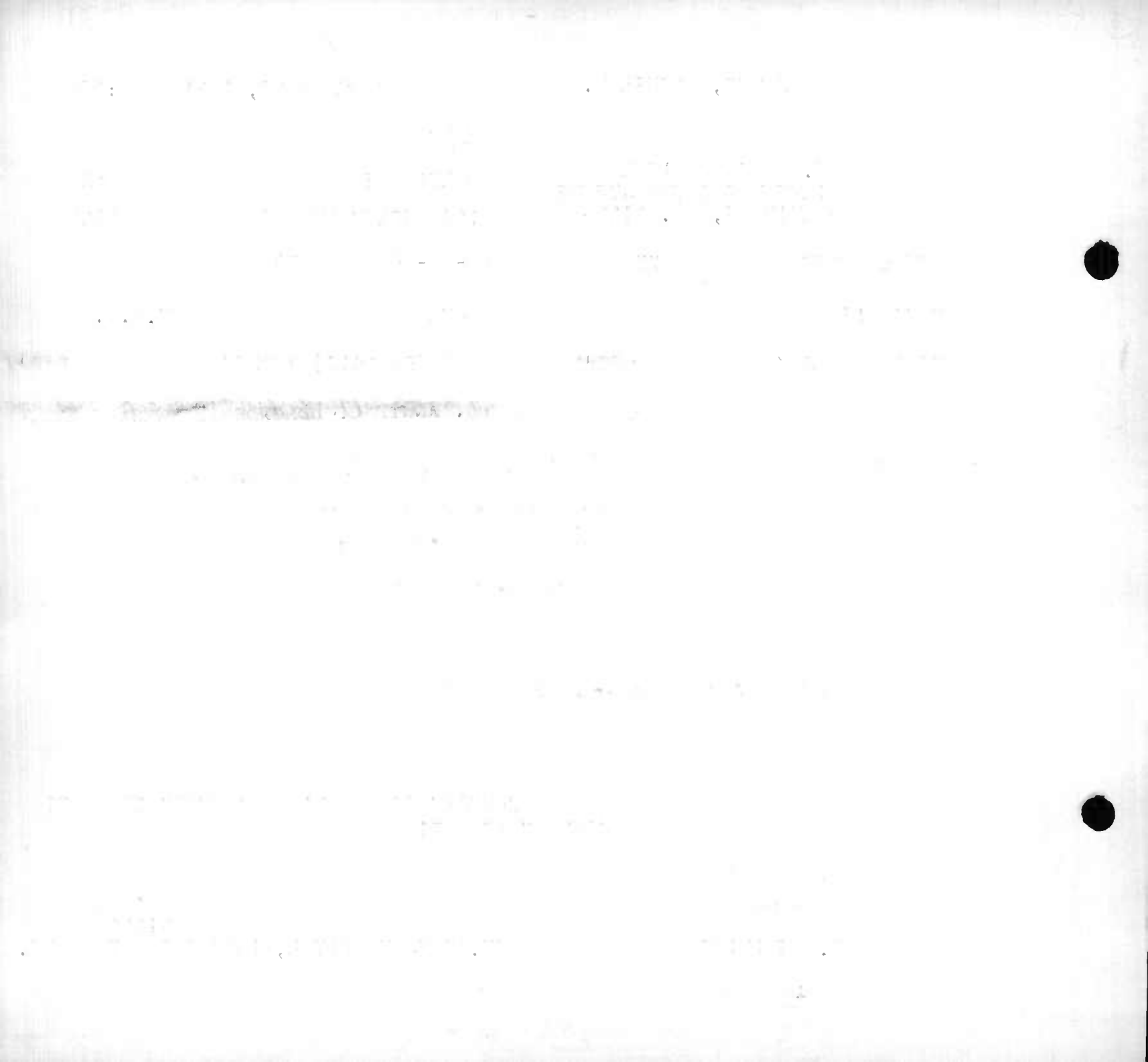
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|--|--|--|--|--|--|
| 71 0789 | | | | | REG. NO. 71 0789 | | | | |
| BIRTH NO. | | | | | 1. NAME OF DECEASED (Type or Print) BERTHA BENNETT | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 2. DATE AND HOUR OF DEATH 1/21/71 8:35 P.M. | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Md. GEN Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY BALTO | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| E. STREET AND NUMBER 721 DRUID PARK LAKE Drive | | | | | | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/26/05 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | 10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family | | 11. BIRTHPLACE (State or foreign country) S. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Wesley White | | | | | 14. MOTHER'S MAIDEN NAME Lillie Jayroe | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 217-07-4693 | | 17. INFORMANT Mr. Daniel Bennett 721 Druid Park Lake | | | | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mycocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (U) (this hospital) attended the deceased from 1/21/71 19 71 to 1/21/71 19 71 that (U) (we) last saw the deceased alive on 1/21/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Bayani B. Elma, M.D. | | | | | 23B. DATE SIGNED 1/21/71 | | 23C. PHYSICIAN'S NAME (Type) BAYANI B. ELMA, M.D. | | |
| 23D. ADDRESS Md. GEN Hosp | | | | | 23E. ADDRESS BALTO. Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-26-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR NOTTER FUNERAL HOME 3035 W. NORTH AVE | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

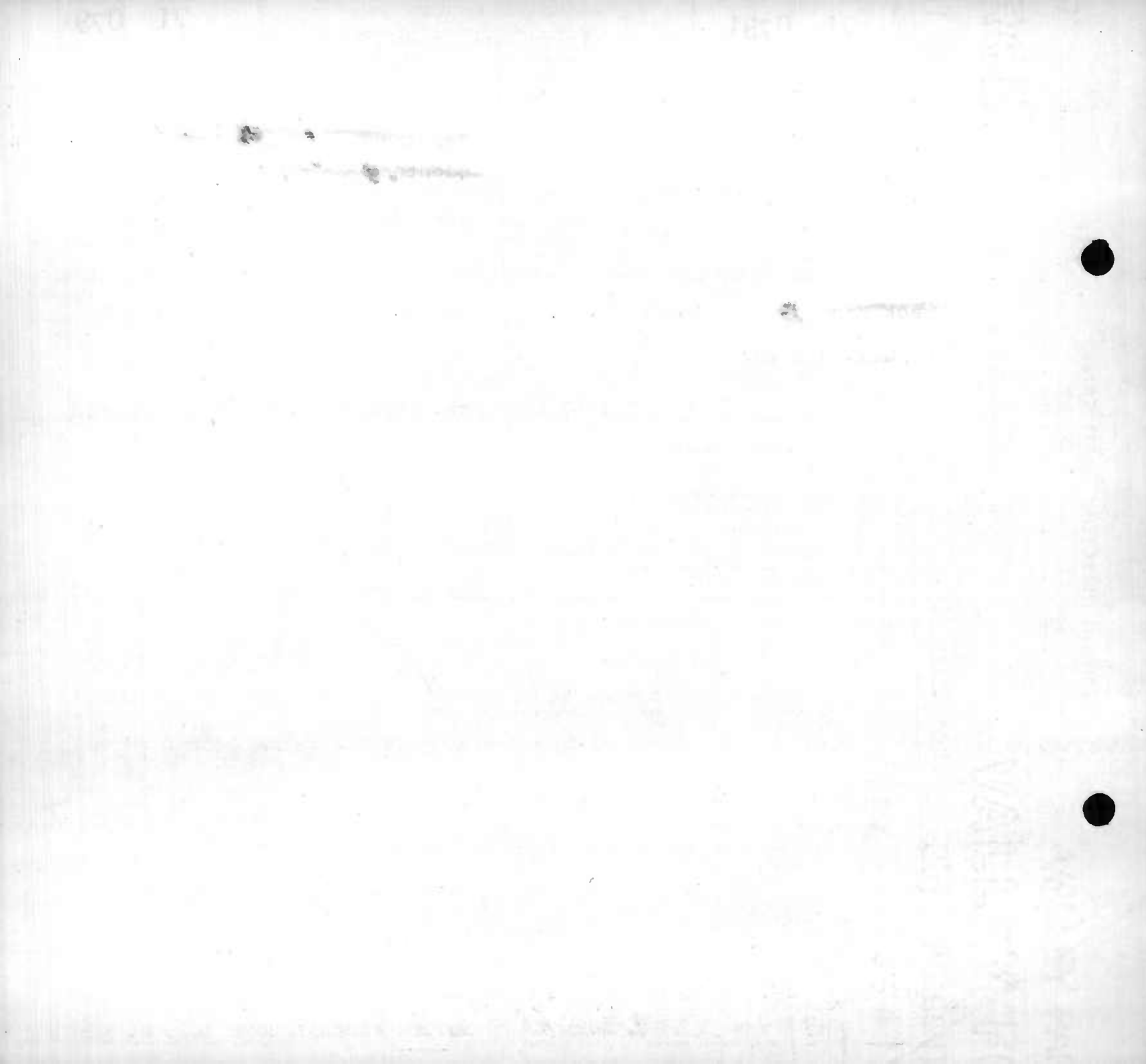
| BIRTH NO. 71 0790 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0790 | |
|--|------------------|---|------------------------------|--|----------------------------|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) JONES, RACHEL M. | | | | 2. DATE AND HOUR OF DEATH JANUARY 20, 1971 8:30P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Muller Co. 53.00 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MD. 21229 | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 126 WESLEY AVENUE | | | | 21228 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 09-25-96 | 9. AGE (in years last birthday) 74 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HENSON DORSEY | | | | 14. MOTHER'S MAIDEN NAME ROSE (FRANCIS) DORSEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212-14-2789 | | 17. INFORMANT MRS. ANNIE C. EDMONDS 126 WESLEY AVE. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE Possible Pulmonary Emboli or Possible Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: completed AV Block with permanent pacemaker (B) Intestinal Volvulus decompress DUE TO, OR AS A CONSEQUENCE OF: (C) Sigmoid Resection | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 15 days 18 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION January 5/1971 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Volvulus | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 05 19 71 to JANUARY 20 19 71 that (I) (we) last saw the deceased alive on JANUARY 20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE V. BENIVITES | | | | 23B. DATE SIGNED 1/20/71 | | 23C. PHYSICIAN'S NAME (Type) V. BENIVITES | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-24-71 | | 24C. NAME OF CEMETERY or CREMATORY HOPKINS CHAPEL CEMETERY | | 24D. LOCATION (City, town, or county) (State) Howard Co. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0791 |
|--|--|---|--|---|
| BIRTH NO. 71 0791 | | 1. NAME OF DECEASED (Type or Print) GALLOWAY ZEAR OLIVER | | |
| 2. DATE AND HOUR OF DEATH 1/21/71 | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD JOHNS HOPKINS HOSPITAL | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Prince Georges C. CITY OR TOWN Odenton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 442 | | 5. SEX MALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5-13-94 9. AGE (In years lost birthday) 73 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Man | | 10B. KIND OF BUSINESS OR INDUSTRY Penna. R. R. | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME Samuel Galloway | | |
| 14. MOTHER'S MAIDEN NAME BERTIE Simms | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 717-07-6553 | | 17. INFORMANT Mrs. Georgianna Galloway ADDRESS Box 442 | | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Ventricular Fibrillation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min. 24 hours. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month (Day) 1 Year (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 1120 19 71 to 1121 19 71 , that (I) (we) last saw the deceased alive on 1121 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE David J. Driscoll MD | | 23B. DATE SIGNED 1/21/71 | | 23C. PHYSICIAN'S NAME (Type) DAVID J. Driscoll |
| 23D. ADDRESS The Johns Hopkins Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 1-25-1971 | | 24C. NAME OF CEMETERY or CREMATORY Saints Rest Cemetery | | |
| 24D. LOCATION Harmons | | 24E. STATE Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert J. ... | | 25C. FUNERAL DIRECTOR NOTTER FUNERAL HOME ADDRESS 3035 W. NORTH AVE |



M 600

71 0792

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0792

| | | | | |
|---|-------------------------|--|--|--|
| 1. NAME OF DECEASED (Type or Print) CECELIA MURRAY | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year January 20, 1971 | | Hour M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1667 West North Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year January 20, 1971 | | Hour 1:45 P. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland | | B. COUNTY 15-01 | | |
| 6. SEX Female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore |
| 9. DATE OF BIRTH 1-6-1908 | | 10. AGE (In years lost birthday) 63 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF USA | | E. STREET AND NUMBER 1667 West North Avenue |
| 13. FATHER'S NAME Emory Taylor | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | |
| 15. MOTHER'S MAIDEN NAME Mary Johnson | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 17. SOCIAL SECURITY NO. 214-20-7197 | | 18. INFORMANT Mr. Pratt Murray | | |
| 19. CAUSE OF DEATH E 953X | | ADDRESS 1667 W. North Avenue | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Hanging DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | | |
| 20A. DATE OF OPERATION 1-20-71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) No |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1667 West North Avenue - (Basement) |
| 22D. TIME OF INJURY (APPROX.) 1-20-71 2 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Hanged self |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |
| DATE SIGNED January 21, 1971 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-23-1971 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AV |

8870

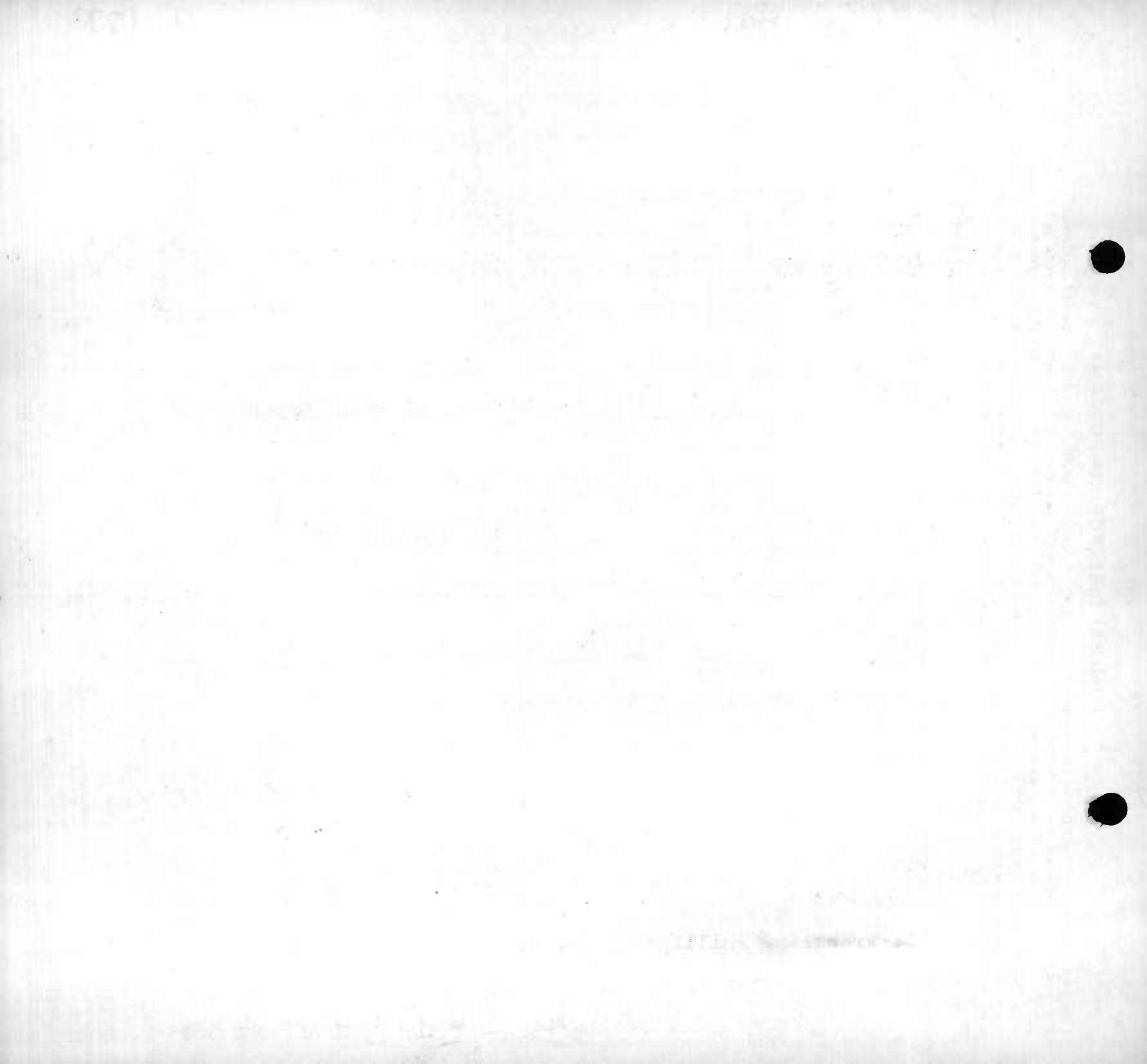
8870

ACADEMIC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0793 | |
|---|--|---|--|--|---|
| BIRTH NO. 71 0793 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Graph G. Greene | | | 2. DATE AND HOUR OF DEATH January 19, 1971 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 27-48 | | |
| 5. SEX Male | | | 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber | | 10B. KIND OF BUSINESS OR INDUSTRY self-employed | | 8. DATE OF BIRTH 7-3-1913 | |
| 11. BIRTHPLACE (State or foreign country) Essex Co. Virginia | | 9. AGE (In years last birthday) 57 | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Mach Greene | | | 14. MOTHER'S MAIDEN NAME Annie M. ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577-03-9765 | | 17. INFORMANT ADDRESS Mrs. M. Pearl Greene 4811 The Alameda | |
| 18. 410-9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary occlusion | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Artery Heart Disease | | | 4 yrs | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/16/66 19 to 1/19/71 19, that (I) (we) last saw the deceased alive on 1/19/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE G. Franklin Phillips M.D. | | | | 23B. DATE SIGNED 1/20/71 | |
| 23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips | | | | 23D. ADDRESS M. Doree 558 McMechan Street Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-23-1971 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Baltimore Co. Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

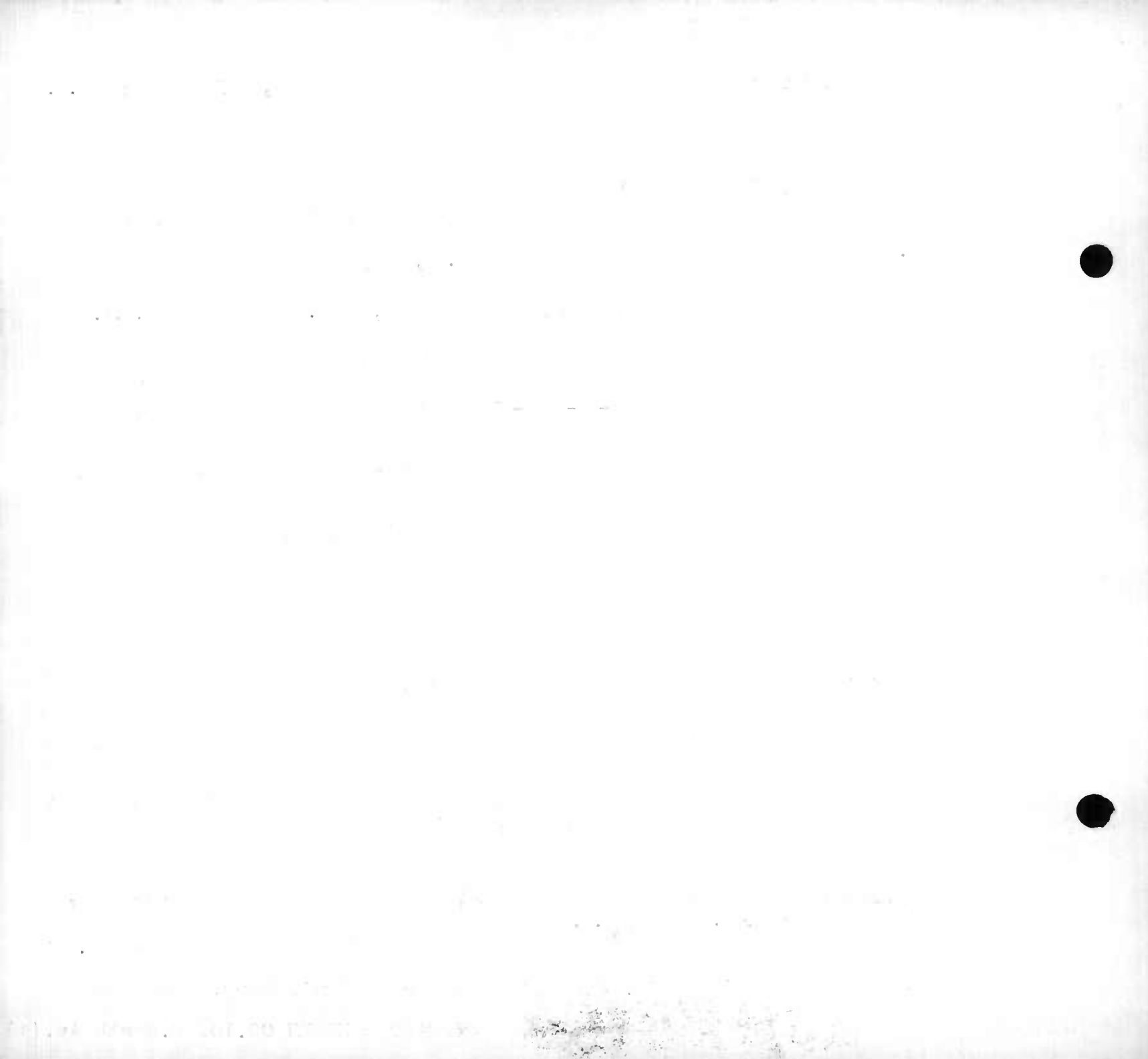
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0794</u> | |
|---|---------|--|------------------|---|-----------------------------|
| 71 0794 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | CLARA RIDGELY (Ridgley) | | JAN. 24 1971 5:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| SINAI HOSPITAL OF BALTIMORE | | 42 | | MARYLAND BALTIMORE 15-04 | |
| | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | |
| | | | | 2321 N. MONROE #17 | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Female | Neard | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8-24-01 | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic | | Pvt. Family | | Maryland | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | |
| ALFRED THOMAS | | | | BESSIE DORSEY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | CHARLES RIDGELY 2321 Monroe St. | |
| 18. <u>410.9 I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | MYOCARDIAL INFARCTION | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 1-19-71 | | CARCINOMA OF CAECUM | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-14-71</u> to <u>1-24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1-24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Leonard Flounders M.D. | | | | 1-24-71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1-28-1971 | | New Cathedral Cemetery | |
| | | | | Baltimore | |
| | | | | Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 26 1971 | | Robert E. Talley, M.D. | | NUTTER FUNERAL HOME 3035 W. NORTH AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0795</u> |
|---|---|---|--|--|
| BIRTH NO. <u>71 0795</u> | | 1. NAME OF DECEASED (Type or Print) <u>Sister Madeleine Norton</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH <u>January 24, 1971</u> <u>9:30 A.M.</u> M. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>94 Villa Saint Michael</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> City <u>City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4000 Forest Hill Road</u> <u>21207</u> | | |
| 5. SEX <u>F.</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 4, 1883</u> | 9. AGE (In years last birthday) <u>88</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Sister of Charity</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cambridge, Mass.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Patrick Nolan</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Hardiman</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>219-54-0663-J1</u> | | 17. INFORMANT <u>Sister Andrea</u> ADDRESS <u>Same address</u> | | |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-vascular collapse</u> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u> | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u> | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>None</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>January 24, 1971</u> that (I) (we) last saw the deceased alive on <u>January 19, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did not</u> view the body after death. | | | | |
| 23A. SIGNATURE <u>Damian P. Azagia</u> DEGREE | | | | 23B. DATE SIGNED <u>January 24, 1971</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>Damian P. Azagia, M.D.</u> <u>3326 Frederick Avenue</u> DEGREE | | | | 23D. ADDRESS <u>3326 Frederick Avenue, Baltimore, Md. 21228</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>1/26/71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | 25B. NAME OF REGISTRAR <u>R. E. Faby, M.D.</u> | 25C. FUNERAL DIRECTOR <u>STEWART & MOWEN CO.</u> ADDRESS <u>108 W. North Av. (1)</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0796 | |
|--|------------------|---|---|---|---|
| 71 0796 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Sister Dorothy Levington | | January 24, 1971 6:50 A.M. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael | | | A. STATE Maryland | | |
| | | | B. COUNTY City | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 4000 Forest Hill Road 21207 | | |
| 5. SEX F. | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 15, 1900 | 9. AGE (In years lost birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | 10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Alfred J. Levington | | 14. MOTHER'S MAIDEN NAME Dorothea Briggman | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-54-0689-T | | 17. INFORMANT Sister Andrea | |
| | | | | ADDRESS same address | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>281.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion</p> <p>(B) _____ DUE TO, OR AS A CONSEQUENCE OF: Pernicious Anemia</p> <p>(C) _____</p> </div> <div style="width: 10%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>1 day</p> <p>20 years</p> </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <input checked="" type="radio"/> None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) None | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July, 1954 19 to January, 1971 19 that (I) (we) last saw the deceased alive on January 19, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Damian P. Alagia</i> DEGREE | | | | 23B. DATE SIGNED January 24, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D. | | | | 23D. ADDRESS 3326 Frederick Avenue, Baltimore, 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | | 24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Emmitsburg, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR <i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av. (1) | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 0797 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0797 | |
|---|----------------------------------|--|-------------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) EDWARD McGINLEY | | 2. DATE AND HOUR OF DEATH 1/21/71 (Jan. 21/71) 4 25 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL MARYLAND GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. Md. B. COUNTY 14-01 C. CITY OR TOWN Balto. Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1419 Bolton St. 1419 Bolton St. | | | |
| 5. SEX Male M | 6. RACE White W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-28-88 | 9. AGE (In years lost birthday) 82 82 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret - Office |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret - Office | | 10B. KIND OF BUSINESS OR INDUSTRY State of Md. | | 11. BIRTHPLACE (State or foreign country) Penn (Norristown, Pa.) | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-36-8905 | | 17. INFORMANT: Wife - Eleanor B. McGinley, 1419 Bolton St. ADDRESS Balto., Md. | |
| 18. 568 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary congestion & edema Small intestinal obstruction Small intestinal obstruction Small bowel adhesions | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION 1/11/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small intest obstruction | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 1/11/71 19 to 1/21/71 19 that (I) (we) last saw the deceased alive on 1/21/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Karl F. Mech, Jr. M.D. | | 23B. PHYSICIAN'S NAME (Type) KARL MECH, JR. | | 23C. DATE SIGNED 1/21/71 | |
| 23D. ADDRESS Maryland Genl Hosp. | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 1/25/71 | | 24C. NAME OF CEMETERY OR CREMATORY Warrington Cemetery | | 24D. LOCATION (City, town, or county) (State) Drexel Hill, Penna. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR James E. Faby, Jr. | | 25C. FUNERAL DIRECTOR STEWART & MOWEN CO. | |
| 25D. ADDRESS 108 W. North Av. City | | | | | |



FUNERAL DIRECTOR: IMPORTANT

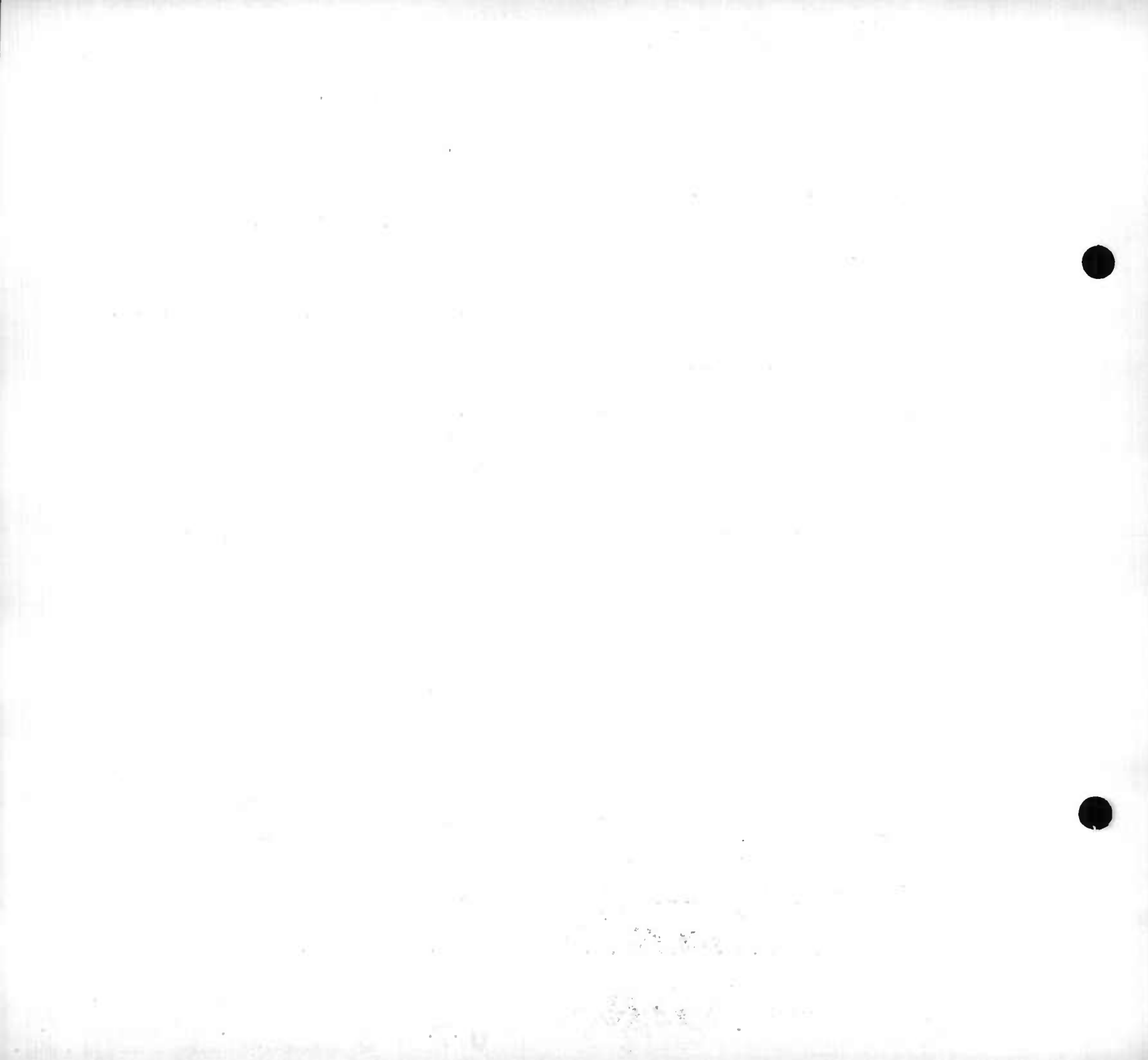
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | REG. NO. | 71 0798 |
|--|--|---------------------|--|---|--|---|--|--|---|--|---------|
| <div style="display: flex; justify-content: space-between;"> 6-450 71 0798 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Frederick F. Gallienne | | | | 2. DATE AND HOUR OF DEATH Jan. 25, 1971 1 7 9 M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2706 N. Calvert Street | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-03 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2706 N. Calvert Street | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-10-1902 | | 9. AGE (In years last birthday) 68 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Trucking | | | | 10B. KIND OF BUSINESS OR INDUSTRY Oil | | 11. BIRTHPLACE (State or foreign country) New York City, N. Y. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Gallienne | | | | | | 14. MOTHER'S MAIDEN NAME Leona Sammis | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 215-03-4104 | | 17. INFORMANT ADDRESS Mrs. Nancy M. Gallienne Same | | | | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio-vascular Disease </div> <div style="width: 35%;"> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div> | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Exogenous obesity | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from May 1966 to Jan 25 1971 that (1) (we) last saw the deceased alive on Dec 31 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Dr. Sheldon Goldgeier | | | | | | | | 23B. DATE SIGNED JAN 25, 1971 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Sheldon Goldgeier | | | | | | | | 23D. ADDRESS 848 W. 36th Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 1-27-1971 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Parkville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | | | 25B. NAME OF REGISTRAR 000 | | | | 25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

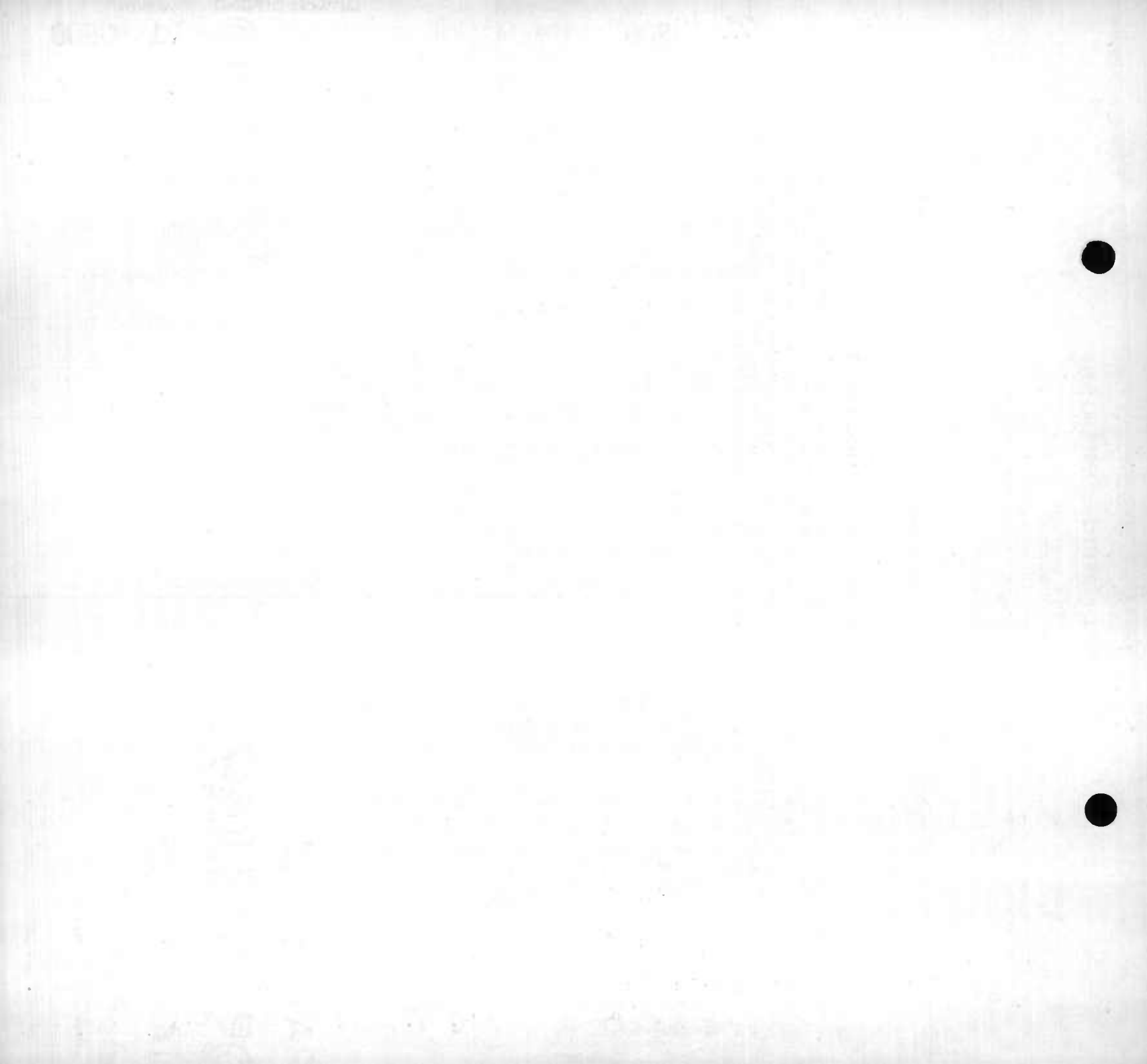
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0799 | |
|--|--|---|--|---|--|
| 71 0799 | | | | 71 0799 | |
| BIRTH NO. R-100 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Anne Riggs Follis Riepe | | 2. DATE AND HOUR OF DEATH Jan. 24, 1971 11:35 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3803 St. Paul St. | | A. STATE Md. | | B. COUNTY 12-01 | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 4-26-06 | | 9. AGE (In years last birthday) 64 | | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Richard H. Follis | | 14. MOTHER'S MAIDEN NAME Louise Riggs | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 215-46-5046 | | 17. INFORMANT J. Creighton Reipe | |
| 18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Cancer (B) Carcinoma of the Breast DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 11 yrs. | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 5, 1970 to Jan. 24, 1971 that (I) (we) last saw the deceased alive on Jan. 23, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Warde B. Allan M.D. | | 23B. DATE SIGNED 1/25/71 | | 23C. PHYSICIAN'S NAME (Type) Warde B. Allan M.D. | |
| 23D. ADDRESS 6 E. Eager St. | | 23E. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-71 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION Pikesville, Md. | | 24E. NAME OF REGISTRAR H. Y. Jenkins | | 24F. FUNERAL DIRECTOR Sons Co. 4905 York Rd. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR H. Y. Jenkins | | 25C. FUNERAL DIRECTOR Sons Co. 4905 York Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0800 | |
|--|--|---|--|---|--|
| H-534 71 0800 | | 71 0800 | | 71 0800 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) RUTH MAE HUNDLEY | | 2. DATE AND HOUR OF DEATH 1/25/71 6:25 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F 6. RACE CAC | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 12/21/06 9. AGE (In years lost birthday) 64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR | | 10B. KIND OF BUSINESS OR INDUSTRY C&P TELEPHONE CO. | | 11. BIRTHPLACE (State or foreign country) PA. | |
| 13. FATHER'S NAME RICHARD G. CROSS | | 14. MOTHER'S MAIDEN NAME IDA MAE JONES | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-03-7219 | | 17. INFORMANT MR. CRAMER HUNDLEY | |
| 18. 431.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) LEFT INTRACEREBRAL HEMMORRHAGE | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: None (B) DUE TO, OR AS A CONSEQUENCE OF: None (C) None | | ADDRESS 1008 MARLEIGH CIRCLE TOWSON APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/24/71 to 1/25/71 19 71 , that (I) (we) last saw the deceased alive on 1/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. L. Wademan, M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/25/71 | |
| 23C. PHYSICIAN'S NAME (Type) R. L. WADEMAN MD | | 23D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-29-1971 | | 24C. NAME OF CEMETERY or CREMATORY Prospect Hill | |
| 24D. LOCATION Towson, | | | | Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Blair E. Blufko | | 25C. FUNERAL DIRECTOR W. J. Johns & Sons Co. | |
| | | | | ADDRESS 4905 York Road Balto., Md. 21212 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-600 | | 71 0801 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0801 | |
|--|---------------------|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Effie CARR | | | | 2. DATE AND HOUR OF DEATH 1/23/71 3:15 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 14-03 | | | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 2318 Etting Street | | | |
| 5. SEX F | 6. RACE B | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/4/82 | | 9. AGE (In years last birthday) 88 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wm. Worthington | | | | 14. MOTHER'S MAIDEN NAME Lucy Dyson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 182-42-2627 | | 17. INFORMANT leara Medely ADDRESS 2662 Oswego Ave. | |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Cardiac Failure | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) A.S.C.V. Disease DUE TO, OR AS A CONSEQUENCE OF: ? | | ? | |
| | | | | (C) Debility DUE TO, OR AS A CONSEQUENCE OF: ? | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | Cardiac Decompensation | | 1 week | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/28 1968 to 1/23 1971 that (I) (we) last saw the deceased alive on 1/23 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph S. Blum | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/25/71 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD | | | | 23D. ADDRESS 11154 CALVERT ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-7-71 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert J. [illegible] | | 25C. FUNERAL DIRECTOR V. Bailey | | ADDRESS 1348 Calhoun St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-----------------------|---|--|---|--|---|--|
| P-630 | | 71 0802 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0802 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>RAH, James</i> | | 2. DATE AND HOUR OF DEATH <i>1-23-71 12:00P. M.</i> | | REG. NO. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Duke and Nursing</i> | | | | A. STATE <i>Maryland</i> | | B. COUNTY <i>15-01</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Home - 1501 N. Duke and</i> | | | | C. CITY OR TOWN <i>BALTO.</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <i>1315 N. WOODMAN ST.</i> | | | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>N C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>6-15-96</i> | 9. AGE (In years last birthday) <i>74</i> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>N. C.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | | | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>218-09-0777</i> | | 17. INFORMANT <i>ESTELLE SMITH</i> | |
| | | | | ADDRESS <i>DURHAM 1501 N. Duke and St.</i> | | | |
| 18. <i>410.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CORONARY OCCLUSION</i> | | | |
| | | | | (B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-28</i> 19 <i>69</i> to <i>1-23</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>1-23</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Thomas W. Harris, M.D.</i> | | | | 23B. DATE SIGNED <i>1-23-71</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>THOMAS W. HARRIS, MD</i> | | | | 23D. ADDRESS <i>4266 EDMONDSON AVE BALTO MD</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1-27-71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1971</i> | | 25B. NAME OF REGISTRAR <i>George L. Bailey</i> | | 25C. FUNERAL DIRECTOR <i>Robert L. Bailey</i> | | ADDRESS <i>1343 N. Calhoun St.</i> | |

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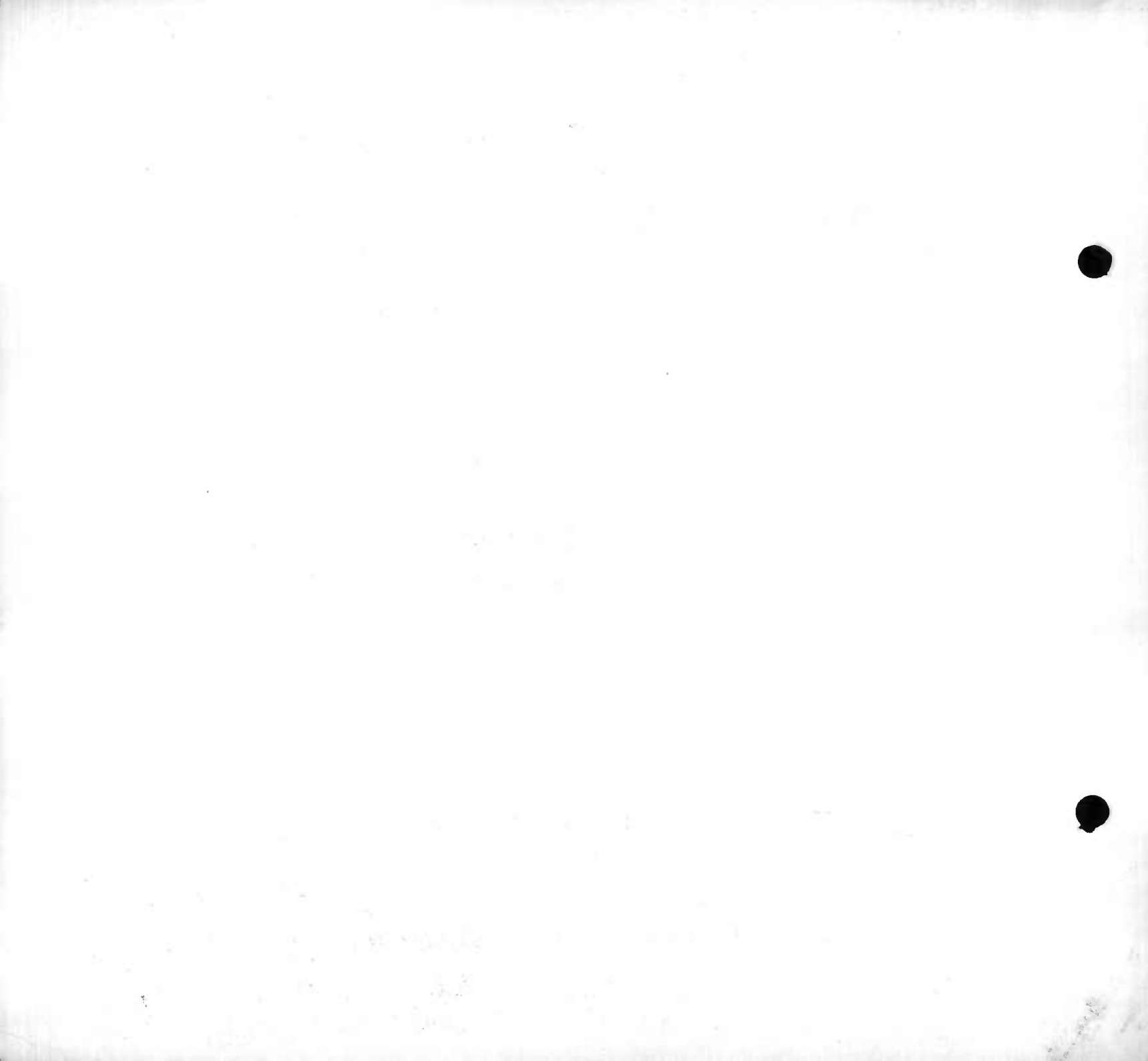
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0803 | | REG. NO. 71 0803 | |
|---|-------------------------|---|--|---|--|---|-----------------------|
| BIRTH NO. <u>B-414</u> | | 71 0803 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Charles Blee field</u> | | | | 2. DATE AND HOUR OF DEATH <u>19 January 1971</u> <u>10:45 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>33 601 N Broadway</u> <u>Baltimore</u> | | | | A. STATE, B. COUNTY <u>Maryland, Baltimore</u> <u>53-00</u> | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>102 Locust Drive</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>Cauc.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-12-1914</u> | 9. AGE (In years lost birthday) <u>56</u> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Education</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>U.S. II</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. <u>354X</u> CAUSE OF DEATH | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiopulmonary Failure</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>Severe Landry-Guillain-Barre syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) <u>S/P 2 cardiac arrests</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> 19 <u>71</u> to <u>Jan 19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Jan 19</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Gary M. Kammer MD</u> | | | | 23B. DATE SIGNED <u>19 Jan 1971</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Gary M. Kammer MD</u> | | | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>1-22-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Md.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Faber MD</u> | | 25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u> | | ADDRESS | |



Body to be turned over to State Board
Board

FUNERAL DIRECTOR: IMPORTANT

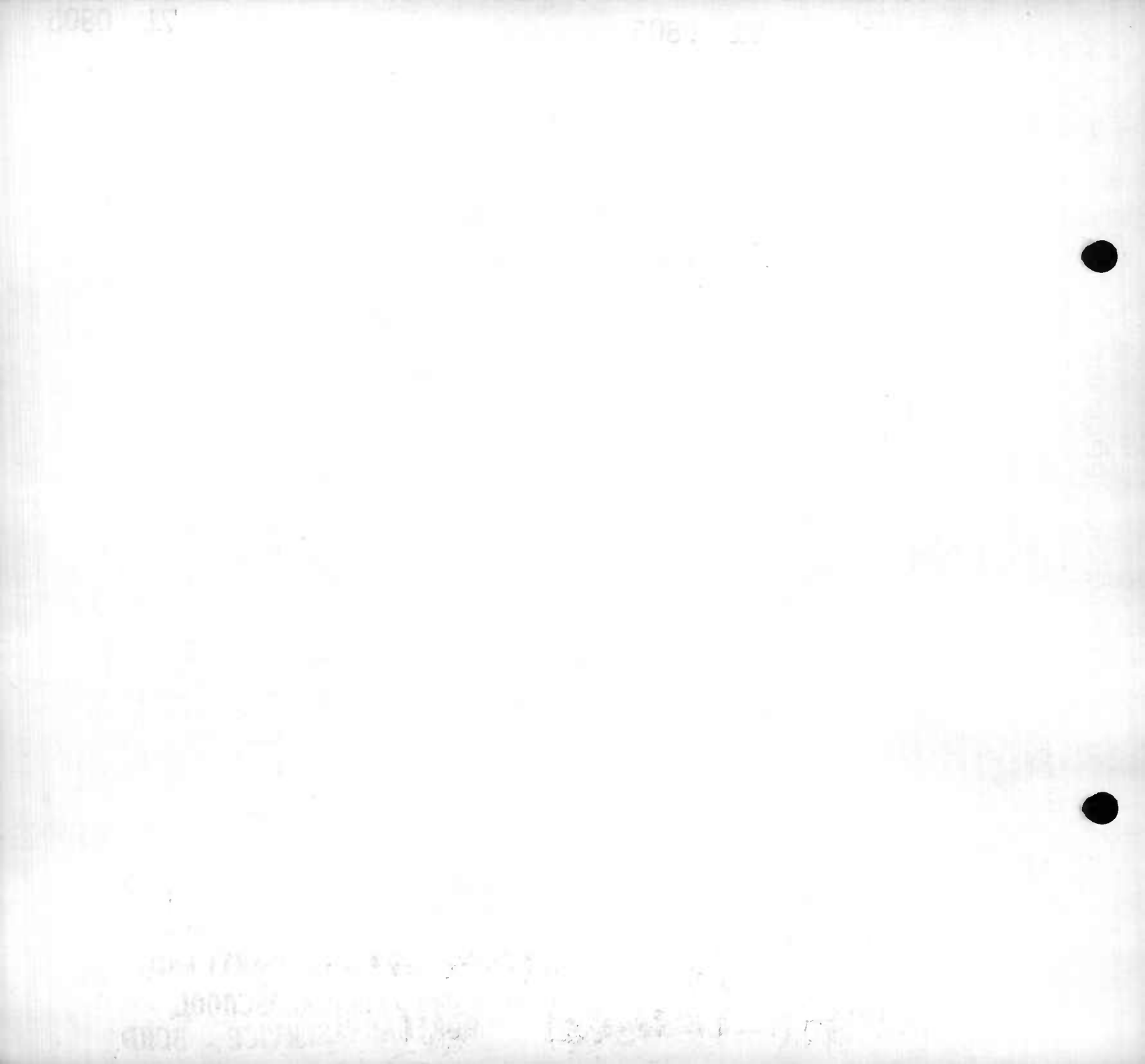
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-630 71 0804 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0804 | |
|---|-------------------------|---|-------------------------------------|---|-------------------------------|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Birk, Betty M.</u> | | | | 2. DATE AND HOUR OF DEATH <u>1/17/71 15:45 a. M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> | | | | A. STATE <u>Maryland</u> | | B. COUNTY <u>Baltimore</u> | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>23 E. 22nd Street</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>05-12-17</u> | 9. AGE (In years last birthday) <u>53</u> | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Michael Saunders</u> | |
| 18. <u>162.1 I</u> CAUSE OF DEATH | | | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Severe Pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF: <u>Possible Lung Cancer</u> | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>1/4</u> 19 <u>71</u> to <u>1/17</u> 19 <u>71</u> that (1) <u>(we)</u> last saw the deceased alive on <u>1/17</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>H. Earl Cotman, M.D.</u> | | | | 23B. DATE SIGNED <u>1/17/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>H. EARL COTMAN, M.D.</u> | | | | 23D. ADDRESS <u>Union Memorial Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1-22-71</u> | | 24C. NAME OF CEMETERY OR CREMATOR <u>ANATOMY BOARD OF MARYLAND</u> | | 24D. CITY, TOWN, OR COUNTY (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u> | | 25C. NAME OF REGISTRAR <u>UNIVERSITY MEDICAL SCHOOL</u> | | 25D. ADDRESS <u>MORTUARY SERVICE - BCHO</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|--|---|--|--|
| L-600 BIRTH NO. 71 006312 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 71 0805 | |
| M.E. CASE NO. 71 006312 | | 0805 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Baby Lowery | | 2. DATE AND HOUR OF DEATH JANUARY 10, 1971 3:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 17-02 | | | |
| D. STREET ADDRESS (If rural, give location) 1310 Euteria Place 21217 | | | | | |
| 5. SEX male | 6. RACE negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 1/10/71 | 9. AGE (In years last birthday) 1 1/2 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Theodore Roosevelt Alfred | | 14. MOTHER'S MAIDEN NAME Bobbi Jean Lowery | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT mother | ADDRESS Same as above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 7777X I | | CAUSE OF DEATH (A) Abortus (380 gm) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1:52 1/10 1971 to 3:30 1/10 1971 that (I) (we) last saw the deceased alive on 3:30 1/10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Chung | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/10/71 | |
| 23C. PHYSICIAN'S NAME (Type) S. Chung | | 23D. ADDRESS Maryland General Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 1-25-71 | | 24B. DATE | | 24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 26 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 71 0806 | |
|---|---------------------|--|------------------------------------|--|--------------------------------|
| G-300 71-00731 0806 | | BIRTH NO. | | 71-00731 0806 | |
| 1. NAME OF DECEASED (Type or Print) <i>Goode, Baby Boy</i> | | 2. DATE AND HOUR OF DEATH <i>11/13/71 at 15-PM</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>Maryland</i> | |
| B. CITY OR TOWN <i>Baltimore</i> | | C. STREET AND NUMBER <i>2105 N. Hilton St</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>M</i> | 6. RACE <i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-13-71</i> | 9. AGE (in years last birthday) | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME <i>Norris, James</i> | | 14. MOTHER'S MAIDEN NAME <i>Esther M Goode</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH <i>Congenital Atelectasis</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>L. Remo Jr.</i> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <i>LAURO C. REMO Jr.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>1-25-71</i> | | 24C. NAME OF CEMETERY or CREMATOR <i>Lutheran Hospital</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR'S ADDRESS <i>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BMD</i> | |

W-326 71 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0807

BIRTH NO.

| | | | |
|--|---|--|---|
| 1. NAME OF DECEASED (Type or Print) James C. Whittaker | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour Month Day Year Hour 1 23 71 10:45p M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 23 71 10:45p M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Carroll | | C. CITY OR TOWN Sykesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 6. SEX male | 7. RACE colored | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH Oct. 5, 1927 | 10. AGE (In years lost birthday) 43 | 11. BIRTHPLACE (State or foreign country) md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George Whittaker | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 15. MOTHER'S MAIDEN NAME Viola Chase | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 218 24 7706 | |
| 18. INFORMANT Mrs. Margaret Whittaker | | ADDRESS Sykesville, Md. | |
| 19. CAUSE OF DEATH 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 1/23/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1-25-71 | 24C. NAME OF CEMETERY or CREMATORY Pineville Cemetery | 24D. LOCATION (City, town, or county) (State) Sykesville Md |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | 25B. NAME OF REGISTRAR Robert E. J. [illegible] | 25C. FUNERAL DIRECTOR Harry W. Hight ADDRESS Sykesville, Md | |

| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. 71 0808 | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|
| BIRTH NO. S-516 | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) RICHARD C. SCHOONOVER | | | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 21 1971 12:40 P.M. | | | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 12th 53-00 | | | | | | | | | | | |
| 6. SEX male | | 7. RACE white | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Woodstock | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 9. DATE OF BIRTH Feb. 19, 1933 | | 10. AGE (in years last birthday) 37 | | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER Old Court Rd. | | | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME James W. Schoonover | | | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logger | | | | 14B. KIND OF BUSINESS OR INDUSTRY Lumber | | 15. MOTHER'S MAIDEN NAME Helen A. Whipp | | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 17. SOCIAL SECURITY NO. 214-36-4239 | | 18. INFORMANT ADDRESS Mr. James W. Schoonover Rt. # 4 Frederick, Md. | | | | | |
| 19. E916X CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Craneo-cerebral injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| (C) _____ | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | | | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3900 Centennel Ave. 63-00 | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 1-20-71 2:39 p. | | | | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? Subj. hit on head by falling tree branch. | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 1-22-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 1-24-1971 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Zion Lutheran Cemetery | | 24D. LOCATION (City, town, or county) (State) Frederick County, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | | | 25B. NAME OF REGISTRAR Robert E. Bailey, M.D. | | | | 25C. FUNERAL DIRECTOR ADDRESS Robert E. Bailey & Son Frederick, Md. 21701 | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0809 | |
|---|--|--|---|--|---|
| C-452 71 0809 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) JESSIE COLLINS | | | 2. DATE AND HOUR OF DEATH JAN 19, 1971 1 845 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY WORCHESTER | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL 38 | | | C. CITY OR TOWN BERLIN | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX M 6. RACE N | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/1/10 |
| 9. AGE (In years last birthday) 60 | | | 10. BIRTHPLACE (State or foreign country) MARYLAND | | 11. CITIZEN OF WHAT COUNTRY? U.S. |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | 13. KIND OF BUSINESS OR INDUSTRY NONE | | |
| 14. FATHER'S NAME Noah Collins | | | 15. MOTHER'S MAIDEN NAME MARY SHOWERL | | |
| 16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 17. SOCIAL SECURITY NO. X | | 18. INFORMANT CHART |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CA MIDESOPHAGUS - METASTATIC | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MOS. | | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CACHEXIA SECONDARY TO CA. | | | | | |
| 22. DATE OF OPERATION 2 | | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 24. AUTOPSY? (Yes or No) Yes | |
| 25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 28. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 30. HOW DID INJURY OCCUR? | |
| 31. I certify that (I) (this hospital) attended the deceased from 1/8/71 19 to 1/19/71 19 that (I) (we) last saw the deceased alive on 1/19/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 32. SIGNATURE J. Oldroyd M.D. | | | | 33. DATE SIGNED 1/19/71 | |
| 34. PHYSICIAN'S NAME (Type) J. S. Oldroyd M.D. | | | | 35. ADDRESS UNIVERSITY HOSPITAL | |
| 36. BURIAL CREMATION, REMOVAL (Specify) Burial | | 37. DATE JAN 27 1971 | | 38. NAME of CEMETERY or CREMATORY Evergreen C.M. | |
| 39. LOCATION (City, town, or county) (State) Berlin Md. | | 40. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 41. NAME OF REGISTRAR R. E. Tabak | |
| 42. FUNERAL DIRECTOR Booker M. Meek | | 43. ADDRESS | | | |

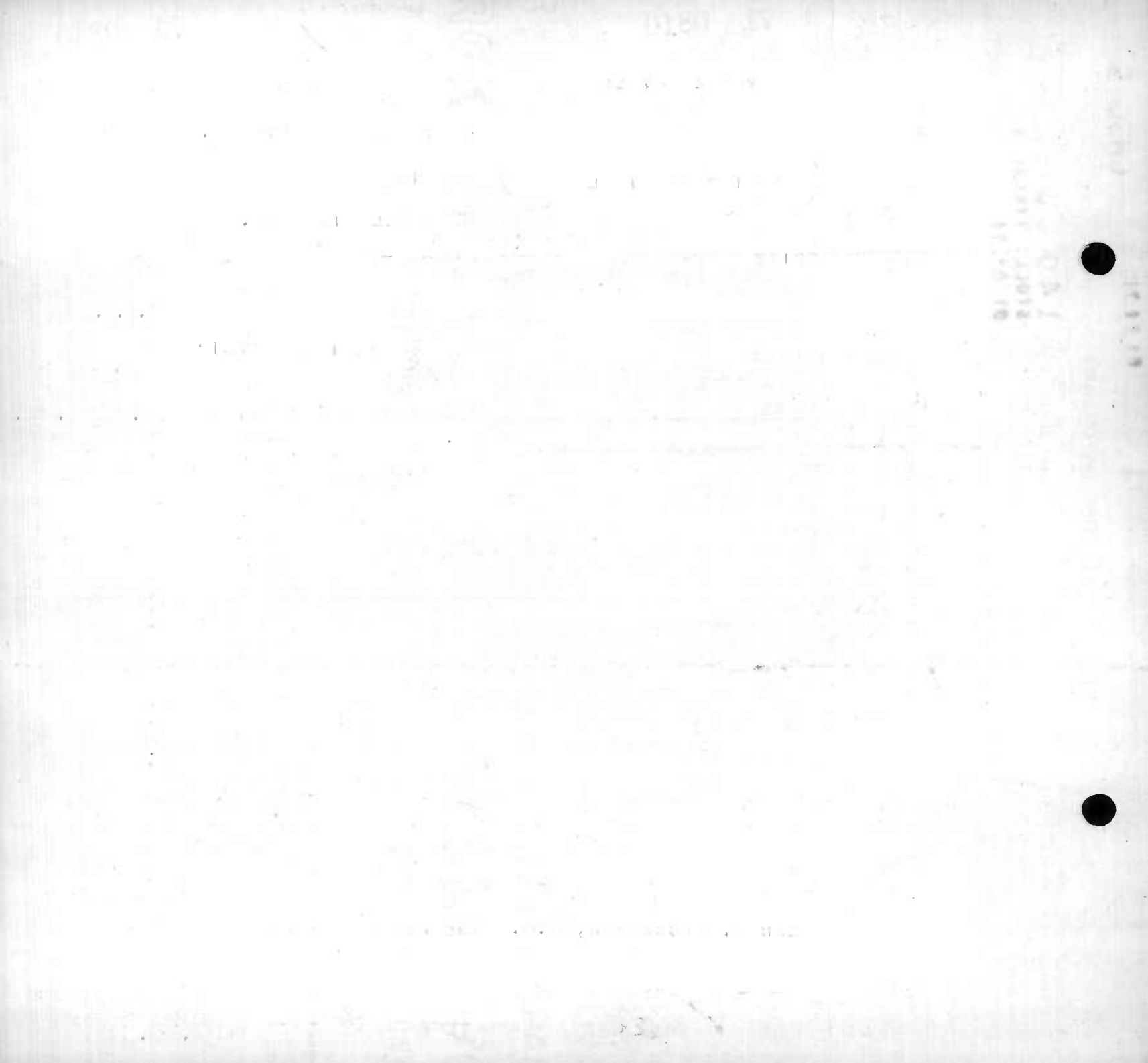
Handwritten text, possibly a signature or name, located in the upper right quadrant of the page.

Handwritten text at the bottom left corner of the page.

FUNERAL DIRECTOR: IMPORTANT

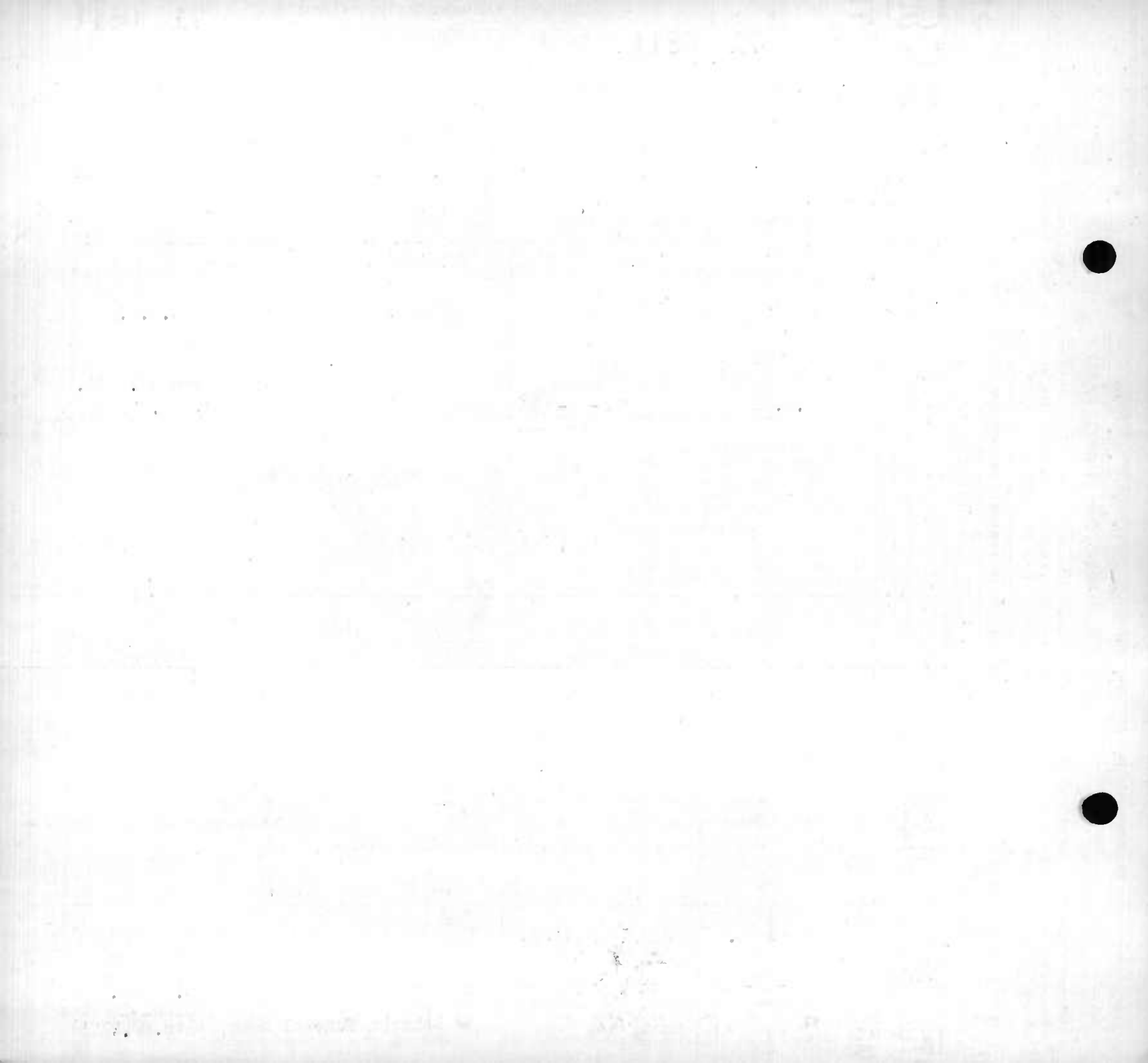
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0810</u> | |
|--|----------------------|--|--|---|---|
| BIRTH NO. <u>S-340</u> | | NAME OF DECEASED (Type or Print) <u>Tyrone Stoll</u> | | DATE AND HOUR OF DEATH <u>Jun 21, 1971 10⁰⁰ A.M.</u> | |
| PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO Co.</u> | | |
| CITY OR TOWN <u>BALTIMORE</u> | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| E. STREET AND NUMBER <u>8219 BEL AIR Rd.</u> | | | | | |
| S. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>01-03-71</u> | | 9. AGE (In years last birthday) <u>17</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>CHRISTOPHER</u> | | 14. MOTHER'S MAIDEN NAME <u>MADELINE PETRI</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>21236</u> | |
| 18. <u>273.01</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intestinal Obstruction</u> | | <u>18 days</u> | |
| ANTECEDENT CAUSES | | (B) <u>Cystic Fibrosis</u> | | <u>18 days</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>Jun 5, 1971</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal Obstruction</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jun 4</u> 19 <u>71</u> to <u>Jun 21</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>Jun 21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Alan E. Zuckerman, M.D.</u> DEGREE | | | | 23B. DATE SIGNED <u>Jun 21, 1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALAN E. ZUCKERMAN, M.D.</u> DEGREE | | | | 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-25-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Garden of Faith</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Fullerton Baltimore Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Zuckerman, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Lassmann Funeral Home</u> ADDRESS <u>7401 Belair Road Balto. Md. 21236</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0811 | |
|--|---------------------|---|--|--|--|
| S-530 BIRTH NO. | | 71 0811 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) SCHMIDT JOSEPH | | | 2. DATE AND HOUR OF DEATH 1-22-71 12 NOON M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 | | | E. STREET AND NUMBER 9802 Pulaski Highway | | |
| 5. SEX m | 6. RACE w | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/24/17 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaping | | 10B. KIND OF BUSINESS OR INDUSTRY Schmidt Sodding | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME Joseph Schmidt | | | 14. MOTHER'S MAIDEN NAME Susan Johnson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. 11 | | 16. SOCIAL SECURITY NO. 820-01-9892 | | 17. INFORMANT John Schmidt | |
| 18. 441.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) OPERATIVE | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC FAILURE DISSECTING ASCENDING THORACIC | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hr | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTIC ANEURYSM WITH Aortic INSUFFICIENCY | | (B) DUE TO, OR AS A CONSEQUENCE OF: 7 DAYS | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1-22-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED THORACIC ANEURYSM | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-22-71 19 to 1-22-71 19, that (I) (we) lost saw the deceased alive on 1-22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James R. Reynold | | | | 23B. DATE SIGNED 1-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) James R. Reynold M.D. | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-71 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery | |
| 24D. LOCATION Fullerton Balto. Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 25B. NAME OF REGISTRAR Robert E. Fabel | | 25C. FUNERAL DIRECTOR U Lessahn Funeral Home, Balto. Md. 21236 | |



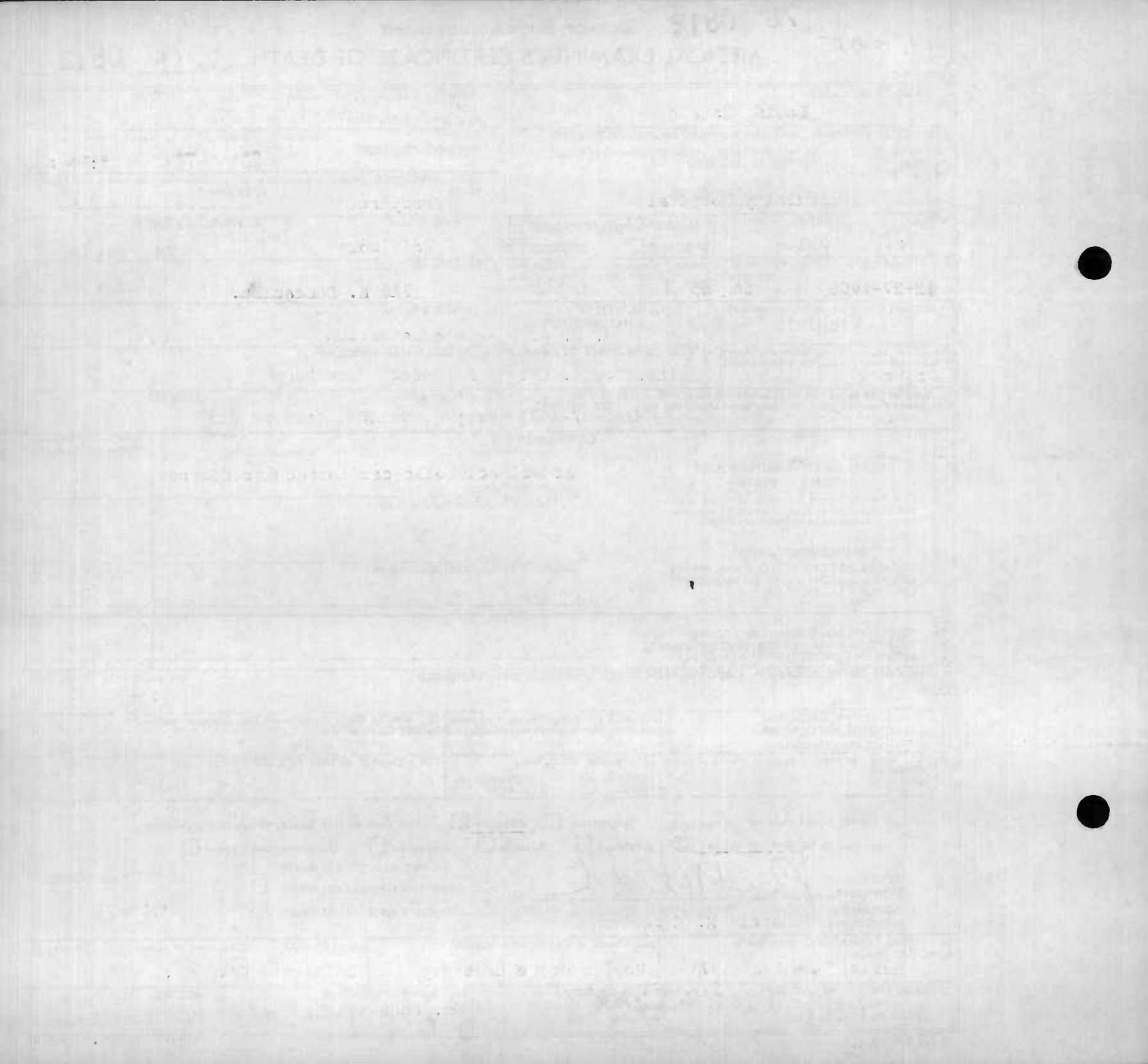
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0812

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) David Watson | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 23 71 1:25 a M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 12-27-1906 | | 10. AGE (in years lost birthday) 64 6# | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 14B. KIND OF BUSINESS OR INDUSTRY Balto. Trans. Co. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 212-07-3939 | |
| 15. MOTHER'S MAIDEN NAME Margaret Rosenbaum | | 18. INFORMANT Mary B. Watson, same as # 5 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 1/23/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Poplar Grove Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 25B. NAME OF REGISTRAR Wm. Cook-Brooks | |
| 25C. FUNERAL DIRECTOR Wm. Cook-Brooks | | 25D. ADDRESS Towson, 1050 York Road Towson, Md. 21204 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> 13-650 71-0813 71 0813 </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH REG. NO. </div> | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Julia Lee Brun</i> | | 2. DATE AND HOUR OF DEATH <i>11.23.71 11.30 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED (If not in hospital or institution, give street address or location) <i>2-3-71</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Balta, Md.</i> B. COUNTY <i>12-03</i> | |
| 5. SEX <i>F</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN <i>Balta City</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i> | | 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | |
| 13. FATHER'S NAME <i>William Demby</i> | | 14. MOTHER'S MAIDEN NAME <i>Emily Price</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>218-22-1086-4</i> | |
| 17. INFORMANT <i>Eugenia Thiel</i> | | ADDRESS <i>2719 St. Paul St.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia of Age</i> (B) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Acute Secondary Anemia</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Subarachnoid Bleeding</i> | |
| 19A. DATE OF OPERATION <i>1-22-71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Subarachnoid Bleeding</i> | |
| 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/> | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <input type="checkbox"/> | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <input type="checkbox"/> | |
| 22. I certify that (I) (the hospital) attended the deceased from <i>1-22-71</i> to <i>1-23-71</i> , and that (I) (we) lost saw the deceased alive on <i>1-22-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Thomas G. Abbott</i> | | 23B. DATE SIGNED <i>1-23-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Thomas G. Abbott</i> | | 23D. ADDRESS <i>4509 Liberty Heights Ave</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1-26-71</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>Indoor Bridge</i> | | 24D. LOCATION (City, town, or county) (State) <i>Dorsey, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert J. Tiekner</i> | |
| 25C. FUNERAL DIRECTOR <i>Wm. J. Tiekner & Sons, Baltimore, Md.</i> | | ADDRESS <i>Wm. J. Tiekner & Sons, Baltimore, Md.</i> | |

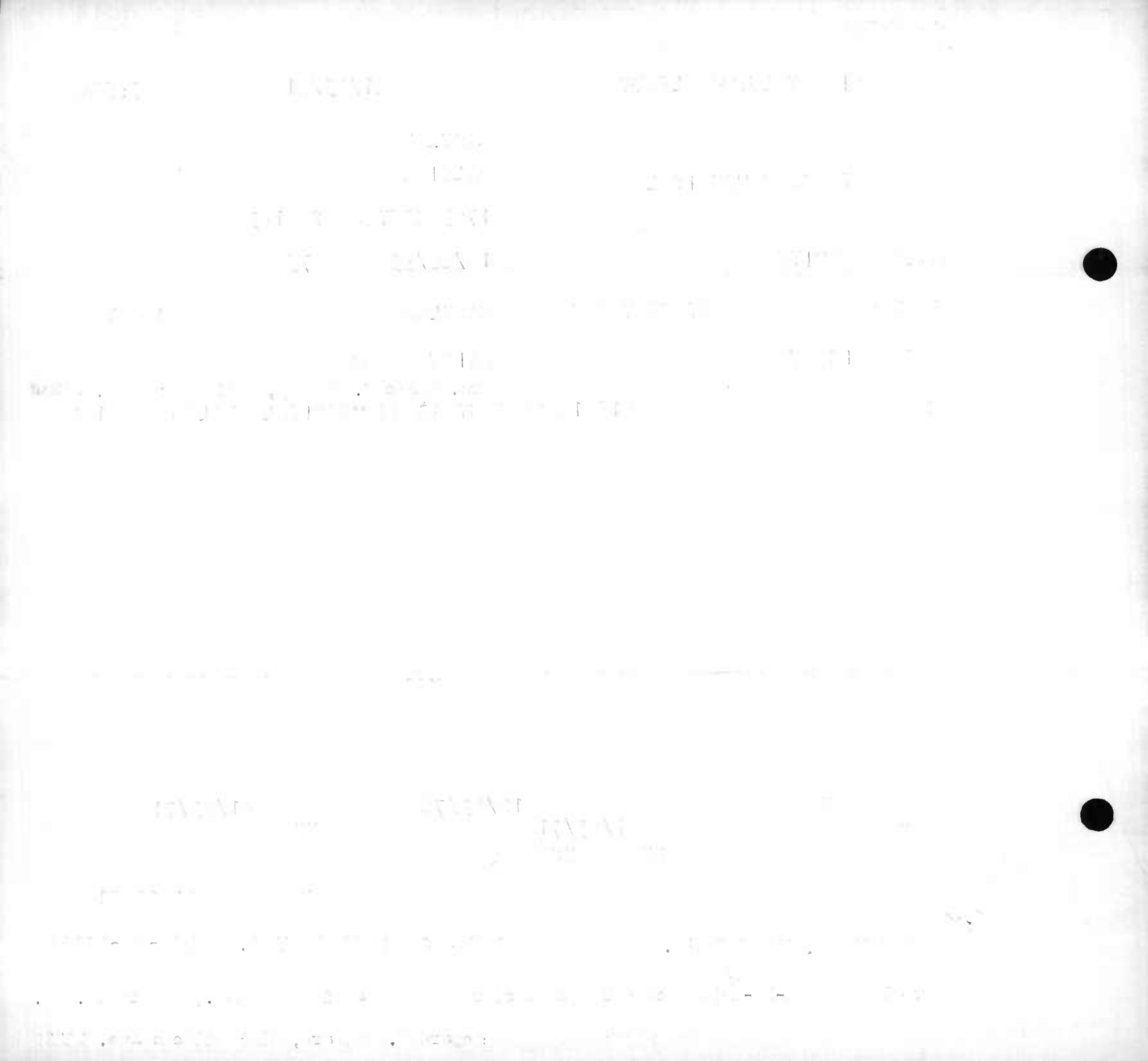
Social Security Card for Julia LeBrun
2-3-71 M.H.

9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

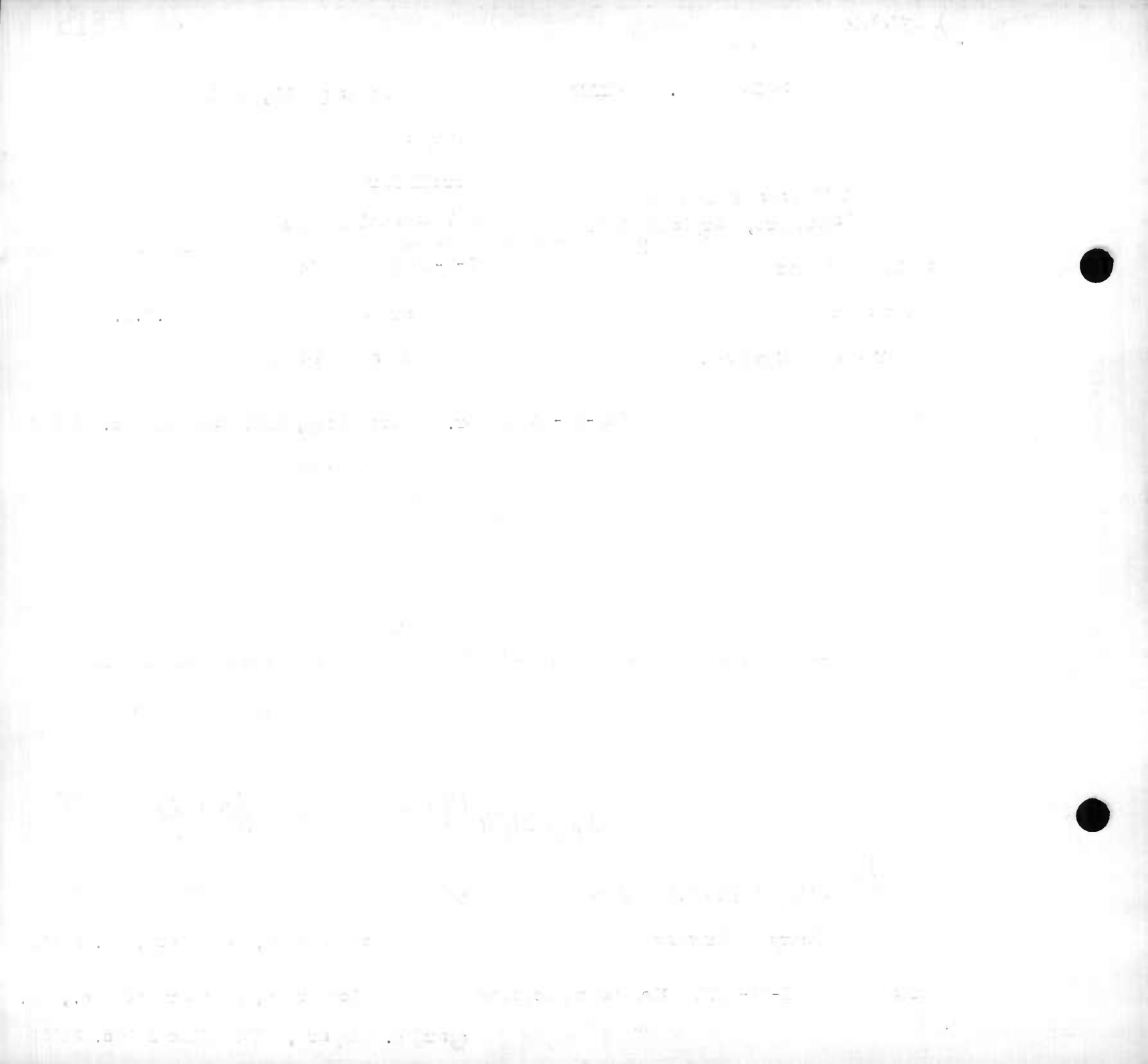
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0814 | |
|--|-------------------------|---|-------------------------------------|--|---|
| BIRTH NO. B-250 71 0814 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) RIGNEY, LUTHER LEROY | | 2. DATE AND HOUR OF DEATH 01/23/71 7:55AM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-53 | | | |
| | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 1703 SEXTON ST 21230 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/02/95 | 9. AGE (In years lost birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY STOCK YARDS | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME PETER RIGNEY | | 14. MOTHER'S MAIDEN NAME DAISY KERR | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218 12 2209 | | 17. INFORMANT Mrs. Elsie G. Rigney, 1703 Sexton St. 21230 ST AGNES HOSPITAL BALTO MD 21229 | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Recent Anteroseptal Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCD Pulmonary Emphysema | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/23/70 19 to 01/23/71 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 01/23/71 19 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE Donato A. Vargas Jr. | | 23B. DATE SIGNED 01 23 71 | | 23C. PHYSICIAN'S NAME (Type) DONATO A. VARGAS JR. | |
| 23D. ADDRESS CATON & WILKENS AVES. BALTO-MD-21229 | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-1971 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Hubbard | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0815 | |
|---|---------|---|---|--|--------------------------------|
| <div style="display: flex; justify-content: space-between;"> 1-300 71 0815 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | JESSIE E. DITTY | | January 22, 1971 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | A. STATE B. COUNTY | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | Maryland | | |
| 1927 Casadel Avenue Baltimore, Maryland 21230 | | | C. CITY OR TOWN Morrell Park | | |
| | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 1927 Casadel Avenue | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Female | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 7-7-1901 | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Homemaker | | | Maryland | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Thomas Thompson | | | Emma DeBaugh | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 213-20-3469B | | Mr. Robert Ditty, 1927 Casadel Ave. 21230 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Acute coronary occlusion minutes | | |
| | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Asevo | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus | | |
| | | | (C) Emphysema - Asthma | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1958 to Jan 21 71 | | | | | |
| that (I) (we) lost saw the deceased alive on Jan 21 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Henry Armanas | | | | Jan 25 71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Henry Armanas | | | | 1934 Wilkens Avenue, Baltimore, Md. 21223 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 1-26-1971 | | Glen Haven Cemetery | |
| 25A. DATE RECD BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 27 1971 | | Howard H. Hubbard | | 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

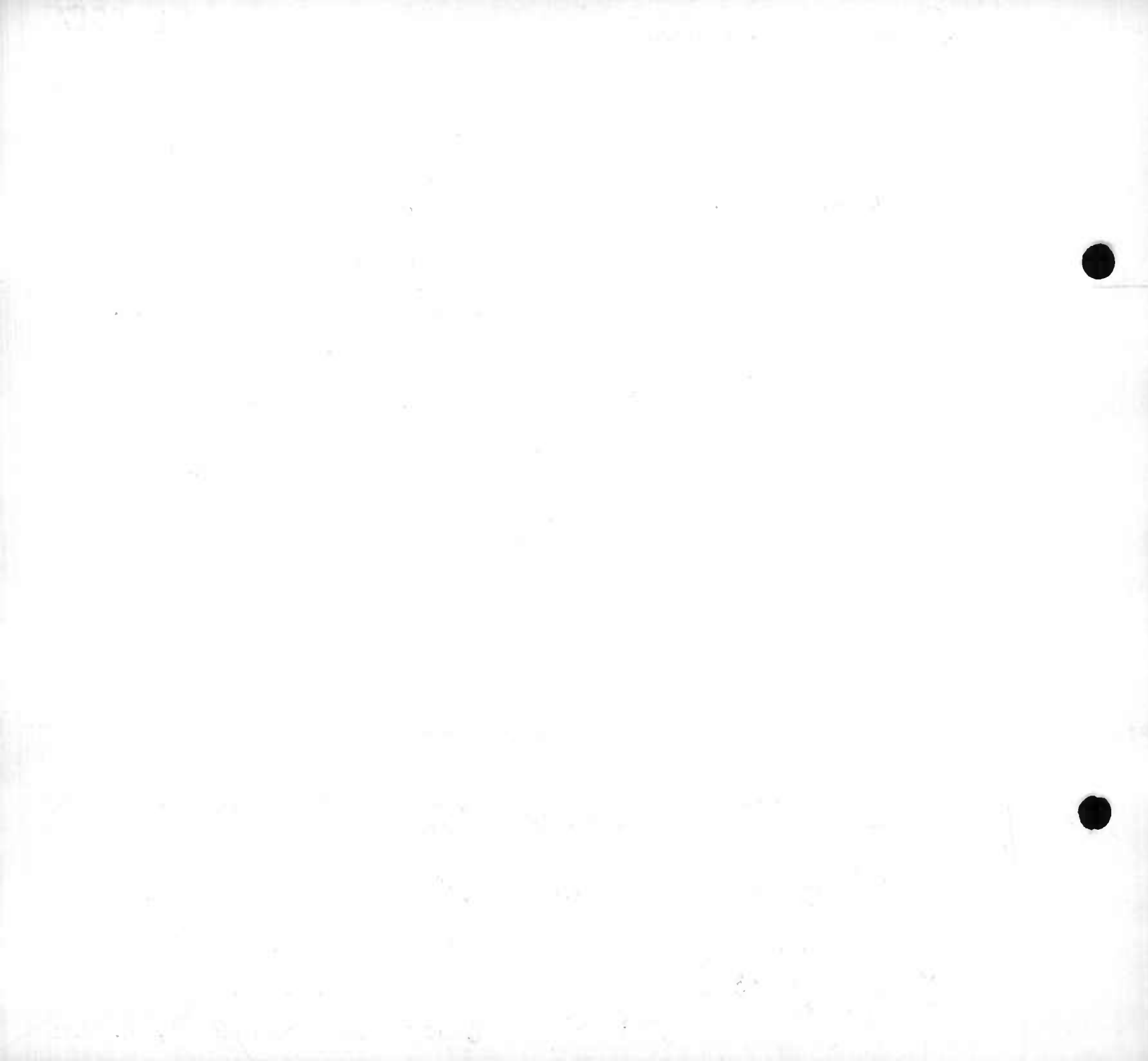
| | | | | | | | |
|---|-------------------------|---|--|--|--|---|---|
| 8-626 | | 71 0816 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0816 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) NEWTON B. PARKER | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH JANUARY 24, 1971 10:18 A.M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 302 ALPINE ROAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE MARYLAND B. COUNTY 27-14 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 302 ALPINE ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-2-1894 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Robert Rouston PARKER | | | 14. MOTHER'S MAIDEN NAME Lucy ALABAMA DENVER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1917-1919 | | | 16. SOCIAL SECURITY NO. 214 07 7535 | | 17. INFORMANT Rouston PARKER | | |
| | | | ADDRESS 302 ALPINE ROAD, BALTO, MD | | | | |
| 18. 41214 I CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: intracerebral cardiovascular accident | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: central hemorrhage | | | |
| | | | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 1970 to Jan 24 1971 and that (I) (we) last saw the deceased alive on June 19 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Francis X. Carmody | | | | | | 23B. DATE SIGNED 1-26-71 | |
| 23C. PHYSICIAN'S NAME (Type) | | DEGREE | | 23D. ADDRESS 3201 N. Charles St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 26 Jan 71 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) BALTO. CO. MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 25B. NAME OF REGISTRAR Robert E. Feltz, M.D. | | 25C. FUNERAL DIRECTOR Large Federal Home | | ADDRESS 3631 Falls Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0817</u> |
|---|--------------------------|--|---------------------------------------|--|
| BIRTH NO. <u>C-200</u> | | 71 0817 | | |
| 1. NAME OF DECEASED (Type or Print) <u>BLANCHE RITTER COX</u> | | 2. DATE AND HOUR OF DEATH <u>23 January 1971</u> <u>10³⁰ A.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>652D Cleveland Ave. 21224</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>652D CLEVELAND AVE.</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>23 March 1893</u> | 9. AGE (In years last birthday) <u>77</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hswf.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Fred Ritter</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Hawkins</u> | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>219-84-2625</u> | | |
| 17. INFORMANT <u>Robert E. Cox, 7616 Dunman Way 21222</u> | | ADDRESS | | |
| 18. <u>290.0 I</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>NUTRITIONAL MARASMAS</u> | | | | <u>5 yrs</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>SENILE DEMENTIA</u> | | | | <u>7 yrs -</u> |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u> | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1970</u> to <u>JAN. 23 1971</u> that (I) (we) last saw the deceased alive on <u>JAN. 15 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>M.B. Davis</u> | | 23B. DATE SIGNED <u>1/25/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>M.B. Davis, MD</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>26 Jan 71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1971</u> | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Cox</u> | | 25C. FUNERAL DIRECTOR <u>Willis H. Fisher</u> | | |
| 25D. ADDRESS <u>1118 E. Dundalk Rd.</u> | | 25E. ADDRESS <u>Dundalk, Md. 21222</u> | | |



1

W-340 71 0818 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0818

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) O'DONNELL A. WHEATLEY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3913 Ridgescroft Road | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 24, 1971 9:00 A. M. | |
| 6. SEX Male | | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. DATE OF BIRTH 5 MAY 1887 | | 10. AGE (In years last birthday) 83 | 11. BIRTHPLACE (State or foreign country) MD. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME DAVID WHEATLEY | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 15. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 212-12-4358 | 18. INFORMANT MR. BLANKHE WHEATLEY |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | 20. DATE OF OPERATION | |
| 21. AUTOPSY? (Yes or No) No | | 22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 24. BURIAL CREMATION, REMOVAL (Specify) BURIAL | |
| 25. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 26. NAME OF REGISTRAR R. G. S. J. R. K. A. D. | |
| 27. DATE OF BIRTH 5 MAY 1887 | | 28. AGE (In years last birthday) 83 | |
| 29. SEX Male | | 30. RACE White | |
| 31. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 32. SOCIAL SECURITY NO. 212-12-4358 | |
| 33. FATHER'S NAME DAVID WHEATLEY | | 34. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 35. INFORMANT MR. BLANKHE WHEATLEY | | 36. ADDRESS 3913 RIDGESCROFT RD | |
| 37. DATE OF BIRTH 5 MAY 1887 | | 38. AGE (In years last birthday) 83 | |
| 39. SEX Male | | 40. RACE White | |
| 41. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 42. SOCIAL SECURITY NO. 212-12-4358 | |
| 43. FATHER'S NAME DAVID WHEATLEY | | 44. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 45. INFORMANT MR. BLANKHE WHEATLEY | | 46. ADDRESS 3913 RIDGESCROFT RD | |
| 47. DATE OF BIRTH 5 MAY 1887 | | 48. AGE (In years last birthday) 83 | |
| 49. SEX Male | | 50. RACE White | |
| 51. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 52. SOCIAL SECURITY NO. 212-12-4358 | |
| 53. FATHER'S NAME DAVID WHEATLEY | | 54. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 55. INFORMANT MR. BLANKHE WHEATLEY | | 56. ADDRESS 3913 RIDGESCROFT RD | |
| 57. DATE OF BIRTH 5 MAY 1887 | | 58. AGE (In years last birthday) 83 | |
| 59. SEX Male | | 60. RACE White | |
| 61. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 62. SOCIAL SECURITY NO. 212-12-4358 | |
| 63. FATHER'S NAME DAVID WHEATLEY | | 64. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 65. INFORMANT MR. BLANKHE WHEATLEY | | 66. ADDRESS 3913 RIDGESCROFT RD | |
| 67. DATE OF BIRTH 5 MAY 1887 | | 68. AGE (In years last birthday) 83 | |
| 69. SEX Male | | 70. RACE White | |
| 71. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 72. SOCIAL SECURITY NO. 212-12-4358 | |
| 73. FATHER'S NAME DAVID WHEATLEY | | 74. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 75. INFORMANT MR. BLANKHE WHEATLEY | | 76. ADDRESS 3913 RIDGESCROFT RD | |
| 77. DATE OF BIRTH 5 MAY 1887 | | 78. AGE (In years last birthday) 83 | |
| 79. SEX Male | | 80. RACE White | |
| 81. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 82. SOCIAL SECURITY NO. 212-12-4358 | |
| 83. FATHER'S NAME DAVID WHEATLEY | | 84. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 85. INFORMANT MR. BLANKHE WHEATLEY | | 86. ADDRESS 3913 RIDGESCROFT RD | |
| 87. DATE OF BIRTH 5 MAY 1887 | | 88. AGE (In years last birthday) 83 | |
| 89. SEX Male | | 90. RACE White | |
| 91. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 92. SOCIAL SECURITY NO. 212-12-4358 | |
| 93. FATHER'S NAME DAVID WHEATLEY | | 94. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 95. INFORMANT MR. BLANKHE WHEATLEY | | 96. ADDRESS 3913 RIDGESCROFT RD | |
| 97. DATE OF BIRTH 5 MAY 1887 | | 98. AGE (In years last birthday) 83 | |
| 99. SEX Male | | 100. RACE White | |
| 101. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 102. SOCIAL SECURITY NO. 212-12-4358 | |
| 103. FATHER'S NAME DAVID WHEATLEY | | 104. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 105. INFORMANT MR. BLANKHE WHEATLEY | | 106. ADDRESS 3913 RIDGESCROFT RD | |
| 107. DATE OF BIRTH 5 MAY 1887 | | 108. AGE (In years last birthday) 83 | |
| 109. SEX Male | | 110. RACE White | |
| 111. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 112. SOCIAL SECURITY NO. 212-12-4358 | |
| 113. FATHER'S NAME DAVID WHEATLEY | | 114. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 115. INFORMANT MR. BLANKHE WHEATLEY | | 116. ADDRESS 3913 RIDGESCROFT RD | |
| 117. DATE OF BIRTH 5 MAY 1887 | | 118. AGE (In years last birthday) 83 | |
| 119. SEX Male | | 120. RACE White | |
| 121. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 122. SOCIAL SECURITY NO. 212-12-4358 | |
| 123. FATHER'S NAME DAVID WHEATLEY | | 124. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 125. INFORMANT MR. BLANKHE WHEATLEY | | 126. ADDRESS 3913 RIDGESCROFT RD | |
| 127. DATE OF BIRTH 5 MAY 1887 | | 128. AGE (In years last birthday) 83 | |
| 129. SEX Male | | 130. RACE White | |
| 131. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 132. SOCIAL SECURITY NO. 212-12-4358 | |
| 133. FATHER'S NAME DAVID WHEATLEY | | 134. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 135. INFORMANT MR. BLANKHE WHEATLEY | | 136. ADDRESS 3913 RIDGESCROFT RD | |
| 137. DATE OF BIRTH 5 MAY 1887 | | 138. AGE (In years last birthday) 83 | |
| 139. SEX Male | | 140. RACE White | |
| 141. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 142. SOCIAL SECURITY NO. 212-12-4358 | |
| 143. FATHER'S NAME DAVID WHEATLEY | | 144. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 145. INFORMANT MR. BLANKHE WHEATLEY | | 146. ADDRESS 3913 RIDGESCROFT RD | |
| 147. DATE OF BIRTH 5 MAY 1887 | | 148. AGE (In years last birthday) 83 | |
| 149. SEX Male | | 150. RACE White | |
| 151. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 152. SOCIAL SECURITY NO. 212-12-4358 | |
| 153. FATHER'S NAME DAVID WHEATLEY | | 154. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 155. INFORMANT MR. BLANKHE WHEATLEY | | 156. ADDRESS 3913 RIDGESCROFT RD | |
| 157. DATE OF BIRTH 5 MAY 1887 | | 158. AGE (In years last birthday) 83 | |
| 159. SEX Male | | 160. RACE White | |
| 161. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 162. SOCIAL SECURITY NO. 212-12-4358 | |
| 163. FATHER'S NAME DAVID WHEATLEY | | 164. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 165. INFORMANT MR. BLANKHE WHEATLEY | | 166. ADDRESS 3913 RIDGESCROFT RD | |
| 167. DATE OF BIRTH 5 MAY 1887 | | 168. AGE (In years last birthday) 83 | |
| 169. SEX Male | | 170. RACE White | |
| 171. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 172. SOCIAL SECURITY NO. 212-12-4358 | |
| 173. FATHER'S NAME DAVID WHEATLEY | | 174. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 175. INFORMANT MR. BLANKHE WHEATLEY | | 176. ADDRESS 3913 RIDGESCROFT RD | |
| 177. DATE OF BIRTH 5 MAY 1887 | | 178. AGE (In years last birthday) 83 | |
| 179. SEX Male | | 180. RACE White | |
| 181. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 182. SOCIAL SECURITY NO. 212-12-4358 | |
| 183. FATHER'S NAME DAVID WHEATLEY | | 184. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 185. INFORMANT MR. BLANKHE WHEATLEY | | 186. ADDRESS 3913 RIDGESCROFT RD | |
| 187. DATE OF BIRTH 5 MAY 1887 | | 188. AGE (In years last birthday) 83 | |
| 189. SEX Male | | 190. RACE White | |
| 191. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 192. SOCIAL SECURITY NO. 212-12-4358 | |
| 193. FATHER'S NAME DAVID WHEATLEY | | 194. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 195. INFORMANT MR. BLANKHE WHEATLEY | | 196. ADDRESS 3913 RIDGESCROFT RD | |
| 197. DATE OF BIRTH 5 MAY 1887 | | 198. AGE (In years last birthday) 83 | |
| 199. SEX Male | | 200. RACE White | |
| 201. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 202. SOCIAL SECURITY NO. 212-12-4358 | |
| 203. FATHER'S NAME DAVID WHEATLEY | | 204. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 205. INFORMANT MR. BLANKHE WHEATLEY | | 206. ADDRESS 3913 RIDGESCROFT RD | |
| 207. DATE OF BIRTH 5 MAY 1887 | | 208. AGE (In years last birthday) 83 | |
| 209. SEX Male | | 210. RACE White | |
| 211. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 212. SOCIAL SECURITY NO. 212-12-4358 | |
| 213. FATHER'S NAME DAVID WHEATLEY | | 214. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 215. INFORMANT MR. BLANKHE WHEATLEY | | 216. ADDRESS 3913 RIDGESCROFT RD | |
| 217. DATE OF BIRTH 5 MAY 1887 | | 218. AGE (In years last birthday) 83 | |
| 219. SEX Male | | 220. RACE White | |
| 221. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 222. SOCIAL SECURITY NO. 212-12-4358 | |
| 223. FATHER'S NAME DAVID WHEATLEY | | 224. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 225. INFORMANT MR. BLANKHE WHEATLEY | | 226. ADDRESS 3913 RIDGESCROFT RD | |
| 227. DATE OF BIRTH 5 MAY 1887 | | 228. AGE (In years last birthday) 83 | |
| 229. SEX Male | | 230. RACE White | |
| 231. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 232. SOCIAL SECURITY NO. 212-12-4358 | |
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| 239. SEX Male | | 240. RACE White | |
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| 243. FATHER'S NAME DAVID WHEATLEY | | 244. MOTHER'S MAIDEN NAME KATE KIRWAN | |
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| 249. SEX Male | | 250. RACE White | |
| 251. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 252. SOCIAL SECURITY NO. 212-12-4358 | |
| 253. FATHER'S NAME DAVID WHEATLEY | | 254. MOTHER'S MAIDEN NAME KATE KIRWAN | |
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| 259. SEX Male | | 260. RACE White | |
| 261. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 262. SOCIAL SECURITY NO. 212-12-4358 | |
| 263. FATHER'S NAME DAVID WHEATLEY | | 264. MOTHER'S MAIDEN NAME KATE KIRWAN | |
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| 269. SEX Male | | 270. RACE White | |
| 271. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 272. SOCIAL SECURITY NO. 212-12-4358 | |
| 273. FATHER'S NAME DAVID WHEATLEY | | 274. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 275. INFORMANT MR. BLANKHE WHEATLEY | | 276. ADDRESS 3913 RIDGESCROFT RD | |
| 277. DATE OF BIRTH 5 MAY 1887 | | 278. AGE (In years last birthday) 83 | |
| 279. SEX Male | | 280. RACE White | |
| 281. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 282. SOCIAL SECURITY NO. 212-12-4358 | |
| 283. FATHER'S NAME DAVID WHEATLEY | | 284. MOTHER'S MAIDEN NAME KATE KIRWAN | |
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| 289. SEX Male | | 290. RACE White | |
| 291. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 292. SOCIAL SECURITY NO. 212-12-4358 | |
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| 299. SEX Male | | 300. RACE White | |
| 301. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 302. SOCIAL SECURITY NO. 212-12-4358 | |
| 303. FATHER'S NAME DAVID WHEATLEY | | 304. MOTHER'S MAIDEN NAME KATE KIRWAN | |
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| 309. SEX Male | | 310. RACE White | |
| 311. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 312. SOCIAL SECURITY NO. 212-12-4358 | |
| 313. FATHER'S NAME DAVID WHEATLEY | | 314. MOTHER'S MAIDEN NAME KATE KIRWAN | |
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| 319. SEX Male | | 320. RACE White | |
| 321. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 322. SOCIAL SECURITY NO. 212-12-4358 | |
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| 329. SEX Male | | 330. RACE White | |
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| 339. SEX Male | | 340. RACE White | |
| 341. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 342. SOCIAL SECURITY NO. 212-12-4358 | |
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| 347. DATE OF BIRTH 5 MAY 1887 | | 348. AGE (In years last birthday) 83 | |
| 349. SEX Male | | 350. RACE White | |
| 351. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 352. SOCIAL SECURITY NO. 212-12-4358 | |
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| 389. SEX Male | | 390. RACE White | |
| 391. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 392. SOCIAL SECURITY NO. 212-12-4358 | |
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| 395. INFORMANT MR. BLANKHE WHEATLEY | | 396. ADDRESS 3913 RIDGESCROFT RD | |
| 397. DATE OF BIRTH 5 MAY 1887 | | 398. AGE (In years last birthday) 83 | |
| 399. SEX Male | | 400. RACE White | |
| 401. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 402. SOCIAL SECURITY NO. 212-12-4358 | |
| 403. FATHER'S NAME DAVID WHEATLEY | | 404. MOTHER'S MAIDEN NAME KATE KIRWAN | |
| 405. INFORMANT MR. BLANKHE WHE | | | |

CERTIFICATE OF DEATH

REG. NO.

71 0819

BIRTH NO.

71 0819

1. NAME OF DECEASED

(Type or Print)

Hall, John S.

2. DATE AND HOUR OF DEATH

1/25/71

1:52 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4940 Eastern Ave. Balto., Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

26-34

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5014 Erdman Ave. 21205

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2-21-10

9. AGE (In years
last birthday)

60

10. Under 1 Yr. 11. Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Volleyball Maker

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John E. Hall

14. MOTHER'S MAIDEN NAME

Berthude Lynch

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH-Records Baltimore, Maryland 21224

18. 440.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. If means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE anoxia
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) ventricular fibrillation
DUE TO, OR AS A CONSEQUENCE OF:(C) arteriosclerosisII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).Prior cerebral thrombosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(Approx.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1 PM 1/25 19 71 to 1:52 PM 1/25 19 71
that (I) (we) last saw the deceased alive on 1/25 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J L Fleg M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/25/71

23C. PHYSICIAN'S
NAME (Type)

J. L. Fleg

MD.

23D. ADDRESS

4940 Eastern Ave. Balto., Md. 21224

Balt. City Hospitals

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/28/71

24C. NAME OF CEMETERY OR CREMATORY

Hall Cem

24D. LOCATION

(City, town, or county)

1501st

WARRASVILLE, W. VA.

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1971

25B. NAME OF REGISTRAR

Robert E. Fleg

25C. FUNERAL DIRECTOR

released to Flekire F.H. Ireland, W. Va.

Higinbotham Black F.H. Ellicott City, Md. 21043

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0820 | |
|--|---|--|--|--|---|
| BIRTH NO. H-655 71 0820 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MARGARET HERRMANN | | | 2. DATE AND HOUR OF DEATH 1/21/71 11:18 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 21-02 | | |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1114 W. CROSS ST. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/6/16 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME BARRETT, WM. | | | |
| 14. MOTHER'S MAIDEN NAME ANNA - BARRETT | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 214-18-1469 | | 17. INFORMANT Husband - ELHER BARRETT HERRMANN ADDRESS 1114 W. CROSS ST. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 1/21 19 71 to 1/21 19 71 that (1) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles T. Weiner, M.D. | | | 23B. DATE SIGNED 1/21/71 | | 23C. PHYSICIAN'S NAME (Type) CHARLES T. WEINER MD |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE 1-25-71 | | 24C. NAME OF CEMETERY OR CREMATORY Neaeharidge Cem. |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | | 25B. NAME OF REGISTRAR Rosa E. J. [unclear] | | 25C. FUNERAL DIRECTOR McCully ADDRESS 130 E. Fort Ave. |

A 81:11

1/21/71

MARGARET HERMANN

x

BALTIMORE

1114 W. CROSS ST.

20

2/21

A. 2. A.

BALTIMORE, MD.

ANNA - BARRETT

HERMANN 1114 W CROSS ST.

HUSBAND - ETHER

unknown

514-18-

NO

UNIVERSITY HOSPITAL

x

F. W.

HOUSEWIFE

BARRETT, B.M.

-

1/21/71

1/21/71

1/21/71

1/21/71

✓

UNIVERSITY HOSPITAL 332 GREENE ST

Charles I. Weiner, M.D.

CHARLES I WEINER, MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 0821 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0821 | |
|--|--|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) LILLIE BROWN | | | 2. DATE AND HOUR OF DEATH 1/25/71 3:15 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission) A. STATE MARYLAND B. COUNTY 7-04 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CORANROA NURSING CENTER 4017 L. BERTY HTS. AVE | | | C. CITY OR TOWN BALTO | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Female 6. RACE BLACK 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | E. STREET AND NUMBER 919 N. CARLINA ST. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRESS | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 1880 9. AGE (in years last birthday) 82 | |
| 11. BIRTHPLACE (State or foreign country) BALTO MD | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME ? | | | 14. MOTHER'S MAIDEN NAME ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Medical Records | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25/71 19 to 1/25/71 19 that (I) (we) last saw the deceased alive on 1/25/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | 23B. DATE SIGNED 1/25/71 | | 23C. PHYSICIAN'S NAME (Type) HOLLIS STEWART |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | | 24B. DATE 1/29/71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. PK |
| 24D. LOCATION (City, town or county) (State) Arbutus, Md. | | | 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | |
| 25B. NAME OF REGISTRAR John E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR Joseph D. Locks, Jr. | | |
| 25D. ADDRESS 1304 N. Central | | | | | |

Handwritten text, possibly a signature or name, oriented horizontally.

Handwritten text, possibly a date or short phrase, oriented vertically.

Handwritten text, possibly a date or short phrase, oriented vertically.

Handwritten text, possibly a date or short phrase, oriented vertically.

Handwritten text, possibly a date or short phrase, oriented vertically.

Handwritten text, possibly a date or short phrase, oriented vertically.

Handwritten text, possibly a date or short phrase, oriented vertically.

Handwritten text, possibly a signature or name, oriented horizontally.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|--|--|---|
| BIRTH NO. 71 0822 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 71 0822 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) THELMA HAMILTON | | 2. DATE AND HOUR OF DEATH 1/22/71 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 7-04 | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION 001636 Ashland AVE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | | | |
| | | D. STREET ADDRESS (If rural, give location) 1636 Ashland AVE. | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 8-23-10 | 9. AGE (In years lost birthday) 60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME WILLIAM WEBB | | | 14. MOTHER'S MAIDEN NAME BERTHA THOMAS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS DIANE WRIGHT 1636 Ashland AVE | | |
| 18. 342X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSING THROMBOSIS | | CAUSE OF DEATH (A) DUE TO PARALYSIS AGITANS | | INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/20 19 70 to 1/22 19 71 , that (I) (we) last saw the deceased alive on 1/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert R. Roper | | | | 23B. DATE SIGNED 1/26/71 | |
| 23C. PHYSICIAN'S NAME (Type) DR. A. L. LAFORREST | | 23D. ADDRESS M.D. 522 N. Bond St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 1/27/71 | 24C. NAME OF CEMETERY or CREMATORY Int. Suburban Cem | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 25B. NAME OF REGISTRAR Case E. Taylor | | 25C. FUNERAL DIRECTOR Joseph A. Lock | |
| | | | | ADDRESS 1304 N. Central | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

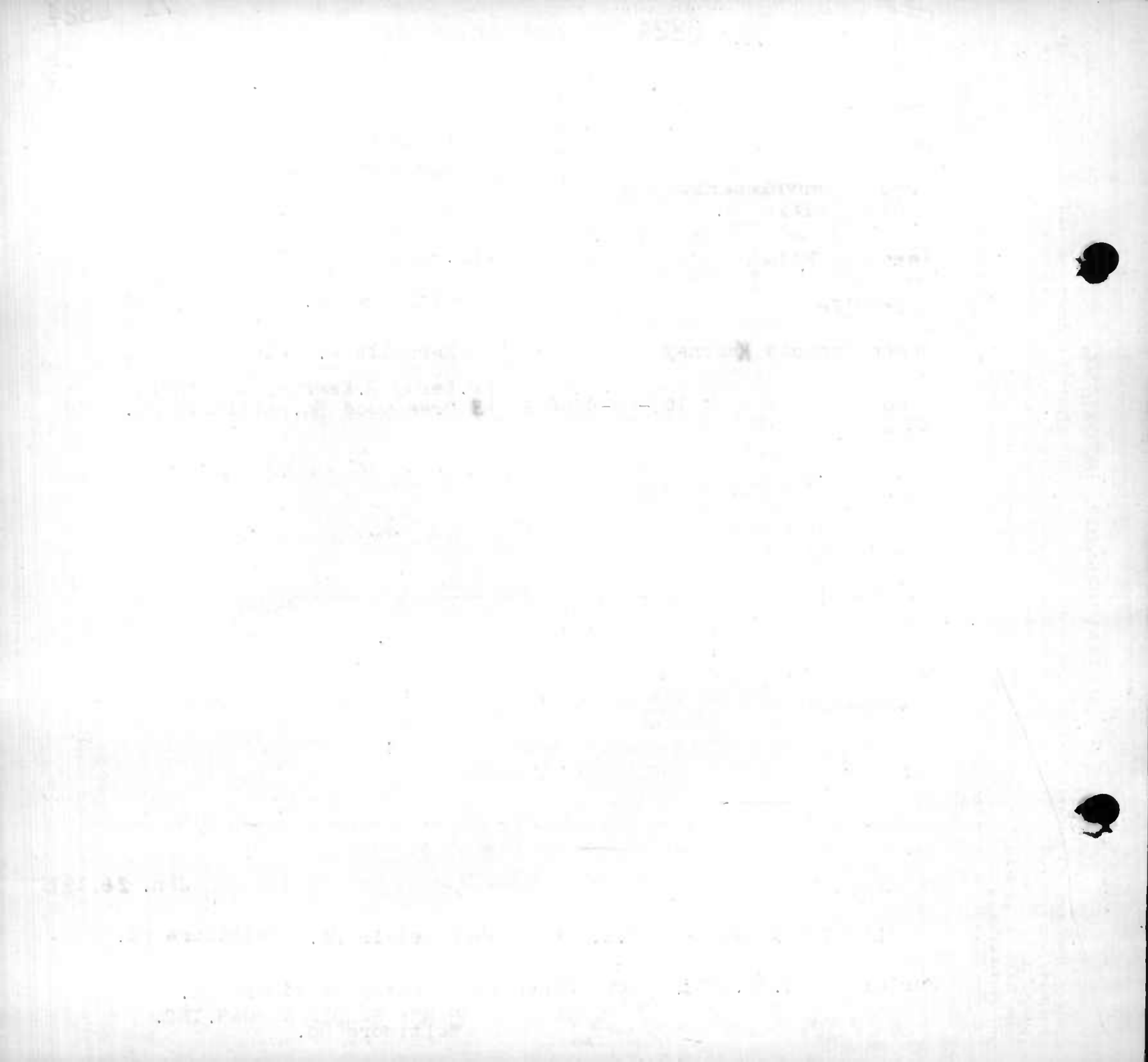
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0823 | | REG. NO. 71 0823 | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. | | 71 0823 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0823 | |
| 1. NAME OF DECEASED (Type or Print) CLARENCE SMITH | | | | 2. DATE AND HOUR OF DEATH 1/25/71 7:45 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21216 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M | | 6. RACE N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH ?? | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years last birthday) 60 yrs | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. 218-84-0710 | | 17. INFORMANT Mrs Jeter, 1614 Riggs Ave | | ADDRESS | |
| 18. 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CARDIO RESPIRATORY FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL HAEMORRHAGE | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 19. DATE OF OPERATION 0 | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? NO INJURY | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/23/71 to 4/25/71 and that (I) (we) last saw the deceased alive on 1/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE K George Thomas MD | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) K GEORGE THOMAS MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/29/71 | | 24C. NAME OF CEMETERY OR CREMATORY MT Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A A County M | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 25B. NAME OF REGISTRAR Robert J. ... | | 25C. FUNERAL DIRECTOR Halstead 1206 W | | ADDRESS North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------|---|--|---|---|
| W-326 BIRTH NO. | | 71 0824 71 0824 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| FRANCES P. WATTS | | | January 24, 1971 10 ⁰⁰ a M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE | | B. COUNTY |
| | | | Maryland | | |
| 90 Gould Convalesarium 6116 Belair Rd. | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore 21218 | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 2713 The Alameda | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Female | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Jan. 6, 1889 | 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | | Baltimore Md. | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| James Francis Kearney | | | Marcella A. Cain | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| no | | 105-09-6206 A | Mr. Leroy R. Kearney (Brother) 43 Greenwood Rd. Baltimore Md. 21206 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (B) Antisepsis, Anesthesia, Pain, etc. DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) Infection of wound & blood stream, Deep burn, Chronic Brain Syndrome; Dehydration; Decubiti. | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED | | |
| | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 12/19/70 to 1/24/71, that (I) (we) last saw the deceased alive on 1/23/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Albert B. Bradley | | | Jan. 26, 1971 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| ALBERT BRADLEY M.D. | | | 4900 Belair Rd. Baltimore Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| Burial | | Jan. 27, 1971 | New Cathedral Cemetery Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 27 1971 | | Robert E. Bradley | | HENRY SANDER & SONS, INC. Baltimore Md. | |



J-525

71 0825

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0825

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Robert J. Johnson | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 23 71 4:00 a | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 23 71 4:00 a | |
| 6. SEX male | | 7. RACE colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 2-21-31 | | 10. AGE (In years lost birthday) 35 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Arthur Johnson | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | |
| 15. MOTHER'S MAIDEN NAME Elsie Winick | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Elsie Johnson | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 965X Gunsight wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) car | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1000 Blk. Braddish Ave. | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1 23 71 ? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? found shot in auto | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL EXAMINER'S SIGNATURE Ronald N. Kornblum, M.D. NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/23/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park Balto Co. | | 24D. LOCATION (City, town, or county) (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 25B. NAME OF REGISTRAR R. E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR Rayner Sanders | | ADDRESS 217 E. Preston St | |

2-21-51

Baltimore
Chaffin
no 1

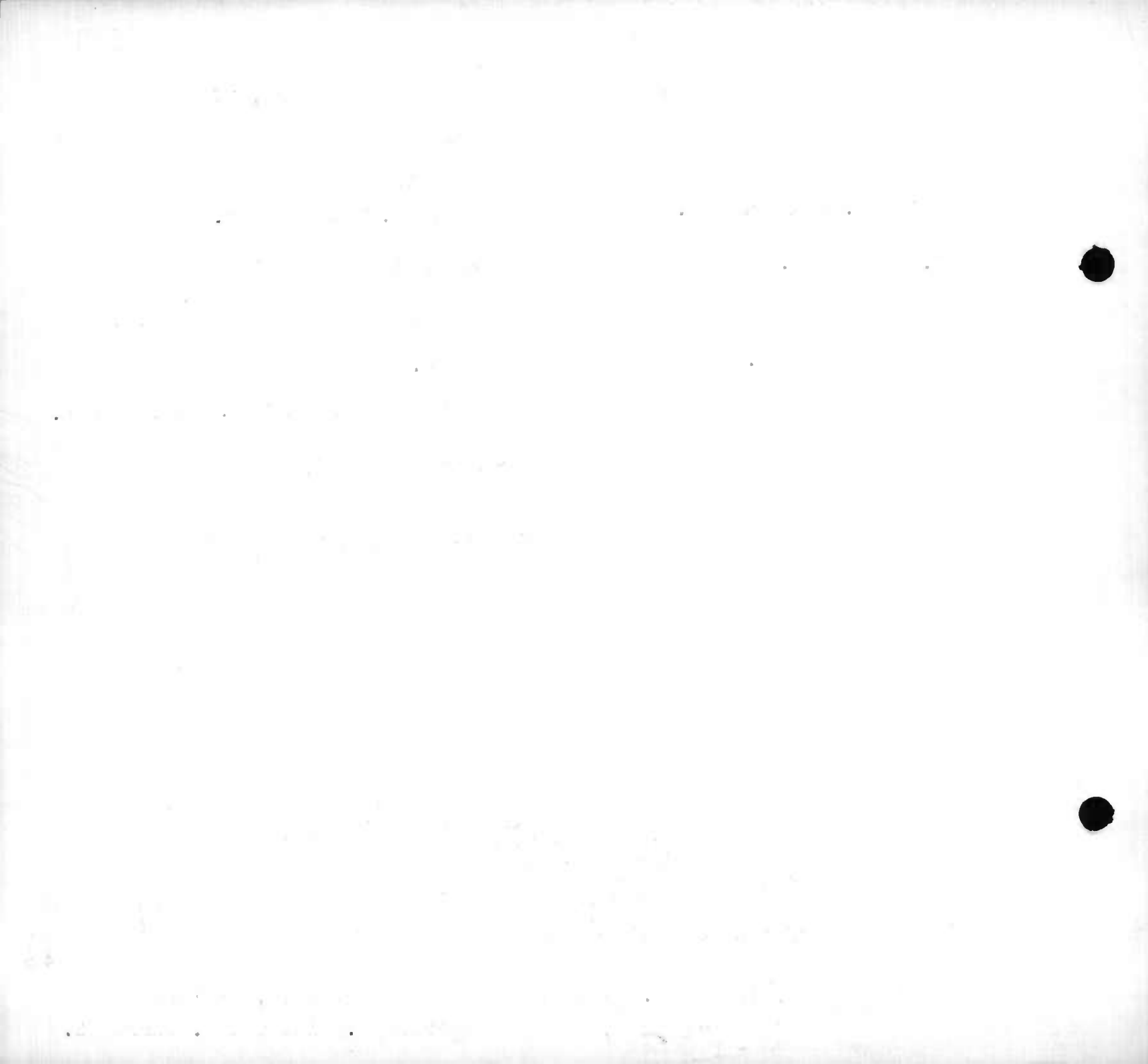
Arthur Johnson
Eliel W. Johnson
Eliel Johnson and family

Boxed 1-21-71
Lester Johnson and family

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>B-400</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0826 CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0826</u> | | | |
|---|--|----------------------|--|--|--|-------------------------------------|--|--|--|----------------------------|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>LUCINDA CYNDA BAILEY</u> | | | | | | | | 2. DATE AND HOUR OF DEATH <u>January 22, 1971</u> M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>713 S. Fremont Ave.</u> | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21-01</u> | | | | | | | |
| | | | | | | | | C. CITY OR TOWN <u>Baltimore</u> | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | E. STREET AND NUMBER <u>713 S. Fremont Ave.</u> | | | | | | | |
| 5. SEX <u>F.</u> | | 6. RACE <u>C.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/15/ 12</u> | | 9. AGE (In years last birthday) <u>58</u> | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Unk.</u> | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Unk.</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Arthur Charles 713 S. Fremont Ave.</u> ADDRESS | | | | | | | |
| 18. <u>410191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC CV DLS.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/19/ 1970</u> to <u>1/22/ 1971</u> that (I) (we) last saw the deceased alive on <u>1/4/ 1971</u> and that (I) (my), (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE <u>John S. Braxton Jr.</u> | | | | | | | | 23B. DATE SIGNED <u>1/25/71</u> | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>JOHN S. BRAXTON JR.</u> | | | | | | | | 23D. ADDRESS <u>612 HILLVIEW RD. BALT. MD.</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>1/27/71</u> | | | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary</u> | | | | 24D. LOCATION (City, town, or county) (State) <u>Brooklyn, Maryland</u> | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 27 1971</u> | | | | 25B. NAME OF REGISTRAR <u>Charles A. Rice</u> | | | | 25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> | | | | ADDRESS <u>661 W. Barre St.</u> | | | |



| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
|---|--|--|--|--|--|--|--|---|--|
| RACHEL YOUNGBLOOD | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | | FULL NAME OF HOSPITAL OR INSTITUTION (If in hospital or institution, give street address or location) | | A. STATE B. COUNTY | |
| University Hospital (DOA) | | Balto. | | 1 20 1971 8:57a | | Md. 21-01 | | | |
| 6. SEX female | | 7. RACE negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 9. DATE OF BIRTH 12-25-02 | | 10. AGE (in years last birthday) 68 | | 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME UNK. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME UNK. | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | | Willie Youngblood | | 659 W. Barre St. | | | |
| 19. CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Carcinoma of breast | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 1-20-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-25-71 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1971 | | 25B. NAME OF REGISTRAR Robert L. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Charles A. Rice | | ADDRESS 661 W. Barre St. | | | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0828

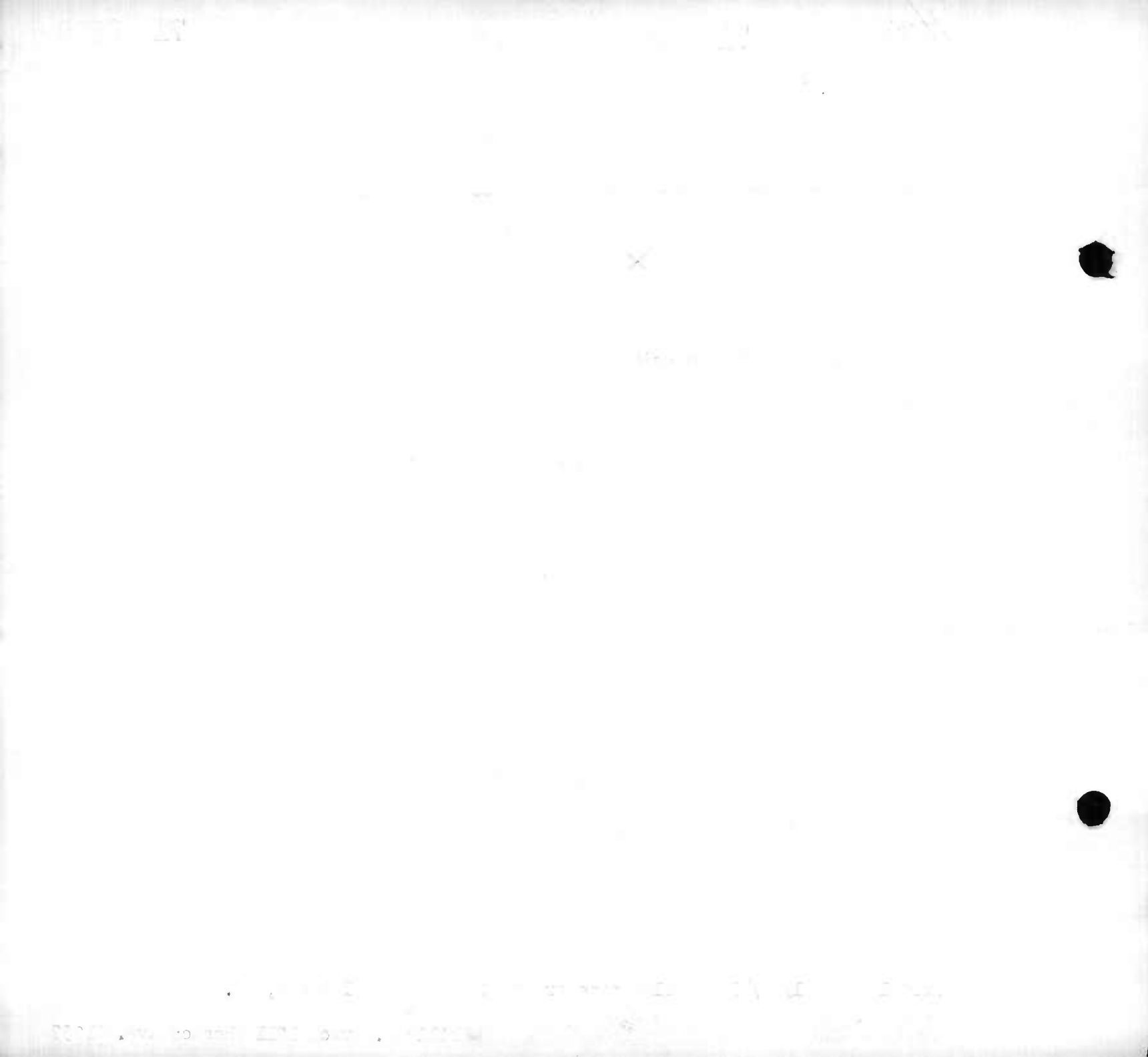
BIRTH NO.

| | | | |
|--|-----------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) WILLIAM VOLMAR | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 26 1971 6:35 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 4/7/15 | | 10. AGE (In years last birthday) 55 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RUBBER STAMP MFG. | | 15. MOTHER'S MAIDEN NAME JANE MILLER | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII 2/60/56/5 | | 17. SOCIAL SECURITY NO. 216015615 | |
| 18. INFORMANT GRACE S. VOLMAR | | ADDRESS | |
| 19. CAUSE OF DEATH 413.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-27-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 1/30/71 | 24C. NAME OF CEMETERY or CREMATORY LOUNDA PARK | 24D. LOCATION (City, town, or county) (State) BALTO. MD. |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. Felt | |
| 25C. FUNERAL DIRECTOR 5500 MAIN ST BB 21228 | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

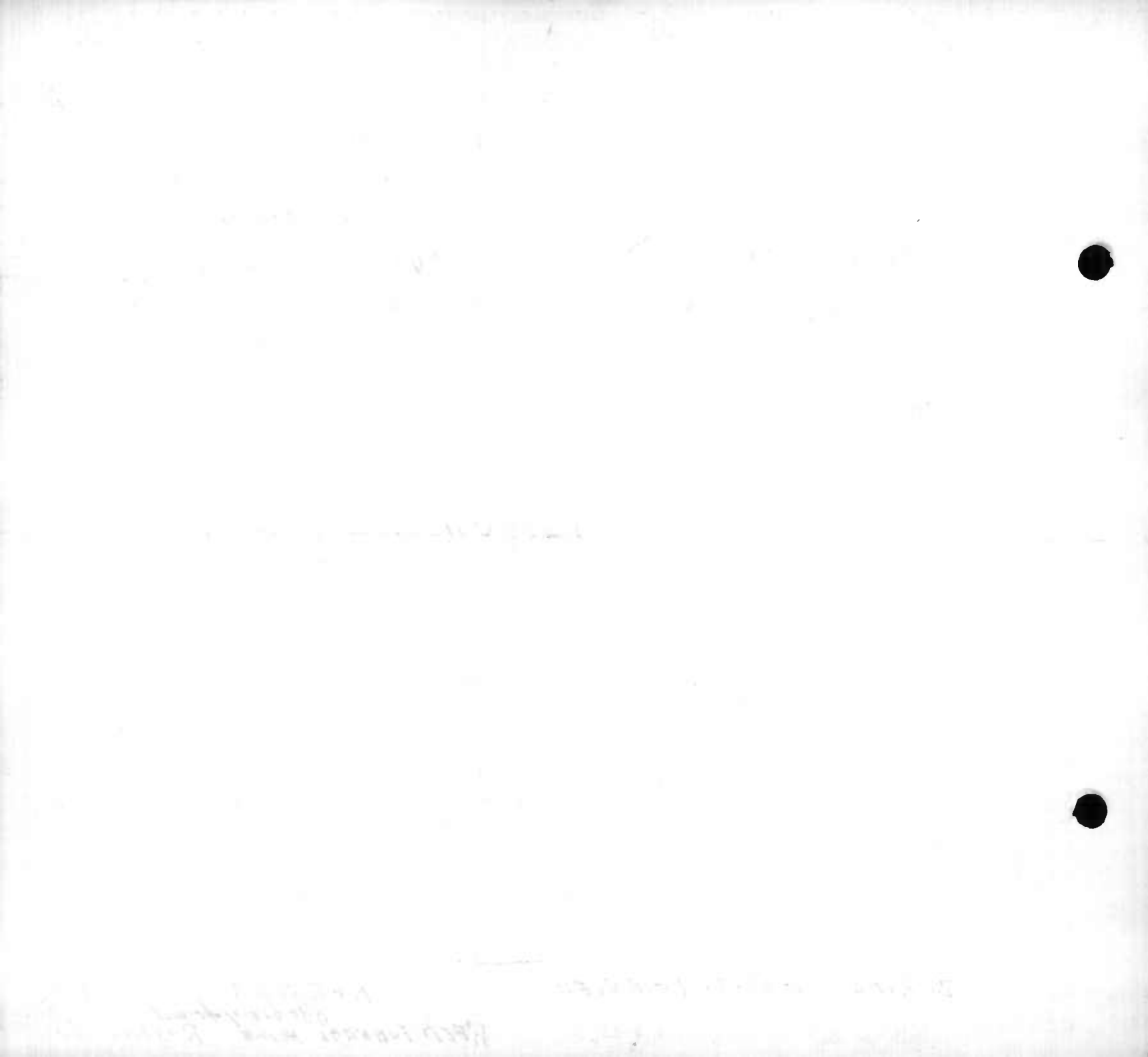
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0829 | |
|--|--|--|--|--|--|
| H-400 | | 71 0829 | | CERTIFICATE OF DEATH | |
| BIRTH NO. H-400 | | | | | |
| 1. NAME OF DECEASED (Type or Print) HALE MRS. ANNA. | | 2. DATE AND HOUR OF DEATH 1/25/71 8-P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 701 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 35 BALTIMORE 21231 | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 12-28-1911 | |
| 13. FATHER'S NAME George Lindeman | | 14. MOTHER'S MAIDEN NAME MARY EWALT | | 9. AGE (In years last birthday) 59 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-01-2618 | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| | | 17. INFORMANT CLARA LANDESMAN | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| | | ADDRESS 703 N. Ken | | | |
| 18. 153.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Small bowel obstructed and perforation | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Secondary to tumor | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Carcinoma Sigmoid Colon | | (B) Carcinoma Sigmoid Colon DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 1/25/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruct | | 20A. AUTOPSY? (Yes or No) — | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/20/71 1971 to 1/25/71 1971 that (I) (we) last saw the deceased alive on 1/25/71 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE T. Sree Ramamurthy | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/ | |
| 23C. PHYSICIAN'S NAME (Type) T. SREE RAMAMURTHY | | 23D. ADDRESS CHURCH HOME AND HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/29/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Philip E. Grach | | 25C. FUNERAL DIRECTOR Philip E. Grach | |
| | | ADDRESS 1211 Chesaco Ave. 21237 | | | |



FUNERAL DIRECTOR: IMPORTANT

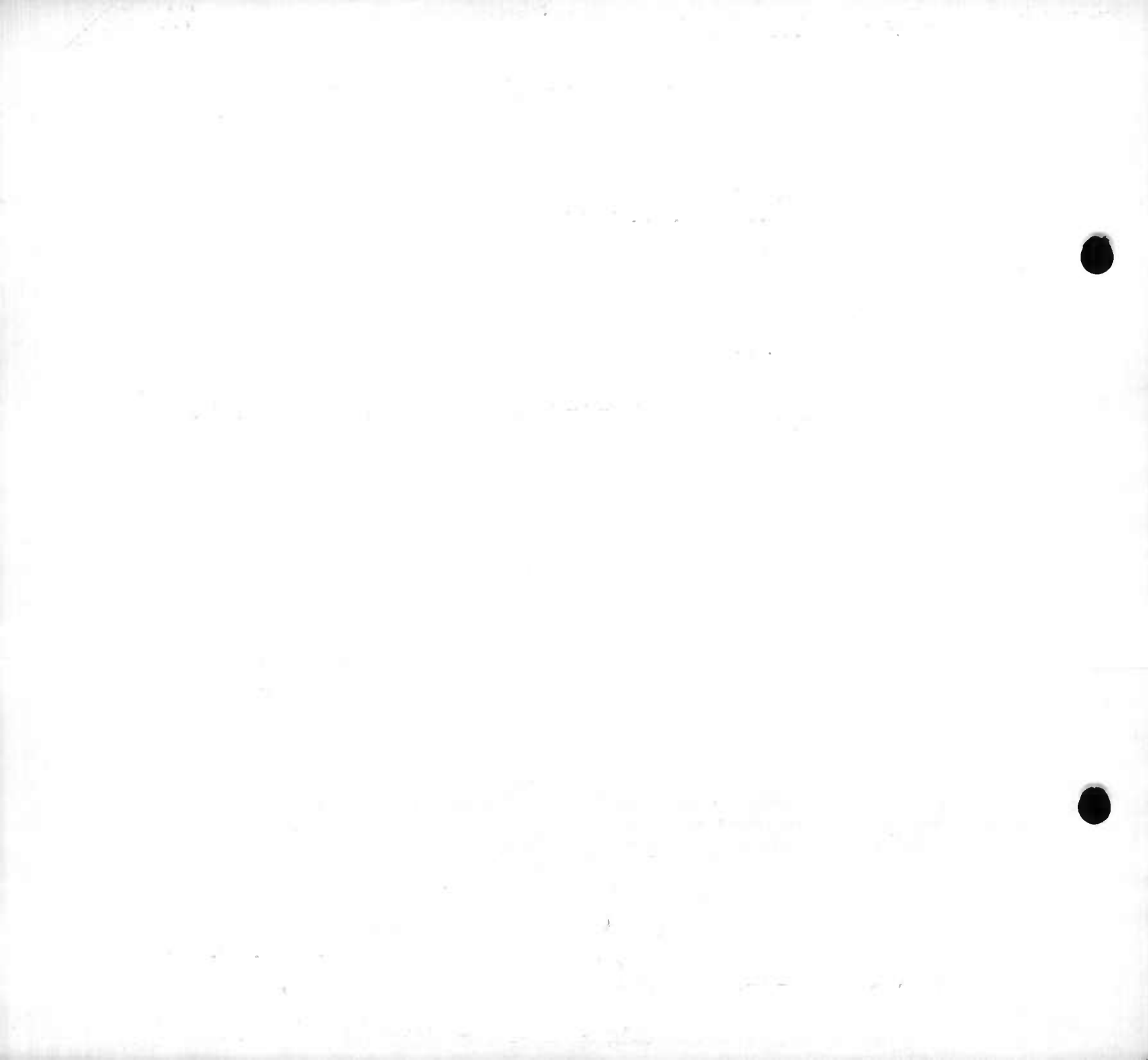
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| K-320 71 0830 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | |
|--|-------------------------|--|--|
| BIRTH NO. | | REG. NO. 71 0830 | |
| 1. NAME OF DECEASED (Type or Print) <u>KOTZ, MRS. FRANCES</u> | | 2. DATE AND HOUR OF DEATH <u>1/23/71</u> <u>5.05</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME & HOSPITAL</u> <u>35</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>1640 RICKENBACKER RD.</u> | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-24-23</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 9. AGE (In years last birthday) <u>47 YRS</u> |
| 13. FATHER'S NAME <u>LEX JOHNSON</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 16. SOCIAL SECURITY NO. <u>224244696</u> | | 14. MOTHER'S MAIDEN NAME <u>L.B. JOHNSON</u> | |
| 17. INFORMANT <u>HERSELF</u> | | ADDRESS <u>SAME</u> | |
| 18. <u>571.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>FATTY METAMORPHOSIS OF</u> DUE TO, OR AS A CONSEQUENCE OF: <u>THE LIVER</u> (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>GASTRIC ULCER, URG</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>1-14-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GASTRIC ULCER, HIATAL HERNIA</u> | |
| 20A. AUTOPSY? (Yes or No) <u>-</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>-</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u> | |
| 21C. WHERE DID INJURY OCCUR? <u>-</u> | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) <u>-</u> | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? <u>-</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-3-71</u> to <u>1-23-71</u> and that (I) (we) lost saw the deceased alive on <u>1/23/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>N. Umrans</u> | | 23B. DATE SIGNED <u>1-23-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>NIZAR UMRAN, M.D.</u> | | 23D. ADDRESS <u>CHURCH HOME & HOSP.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-27-71</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u> | | 24D. LOCATION (City, town, or county) (State) <u>NARROWS VA</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>REED FUNERAL HOME</u> | |
| 25C. FUNERAL DIRECTOR <u>REED FUNERAL HOME</u> | | ADDRESS <u>RISING SUN</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

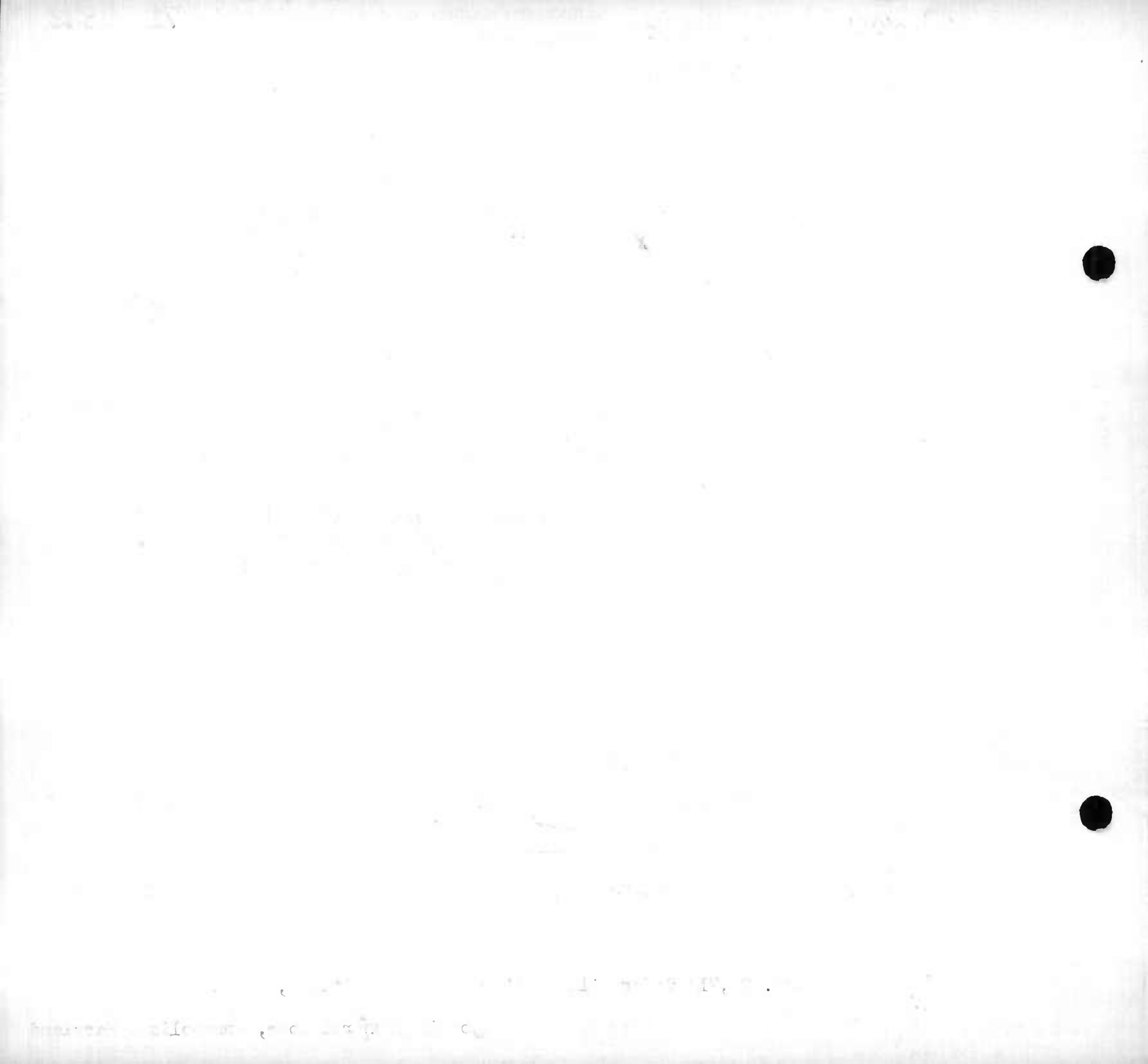
| | | | | | | | |
|--|--|--|--|---|--|--|--|
| F-620 71 0831 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 71 0831 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | John Fries (FRIES) | | 2. DATE AND HOUR OF DEATH | | Jan 24 1971 11:10 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Va. Warren V-43 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| Baltimore City Hospitals, Baltimore, Md. 4940 Eastern Ave., Balto. Md. 21224 | | Front Royal | | YES <input type="checkbox"/> | | NO <input checked="" type="checkbox"/> | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11/13/36 | |
| 9. AGE (In years last birthday) | | 34 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| 10A. USUAL OCCUPATION | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE | | 12. CITIZEN OF WHAT COUNTRY? | |
| Controller | | Virginia cap. | | Iowa | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Edward H. Fries | | Lamona Fagan | | 482-40-91-46 | | 17. INFORMANT | |
| 15. Was Deceased Ever in U. S. Armed Forces? | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| (Yes, no or unknown) (If yes, give war or dates of service) | | 482-40-91-46 | | BCH Records: Baltimore, Md. 21224 | | 4940 Eastern Avenue | |
| 18. 200.0 I | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Probable Sepsis | | 12 hrs. | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) RETICULUM CELL SARCOMA | | 6 1/2 years | | | |
| ANTECEDENT CAUSES | | (C) @ Pleural effusions | | 1 month | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 me | | none | | Yes. | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | Jan 11 19 71 to Jan 24 19 71 | | | | | |
| that (I) (we) lost saw the deceased alive on | | Jan 24 19 71 and that in (my) (our) opinion death occurred on the date | | | | | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | | | |
| David Juan | | Jan 24, 1971 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | |
| DAVID JUAN | | Baltimore City Hosp. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 1-29-71 | | Oakland Cemetery | | Keokuk, Iowa | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 28 1971 | | V. E. Fries | | 3021 EASTERN AVE. | | BALTIMORE, MD 21224 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

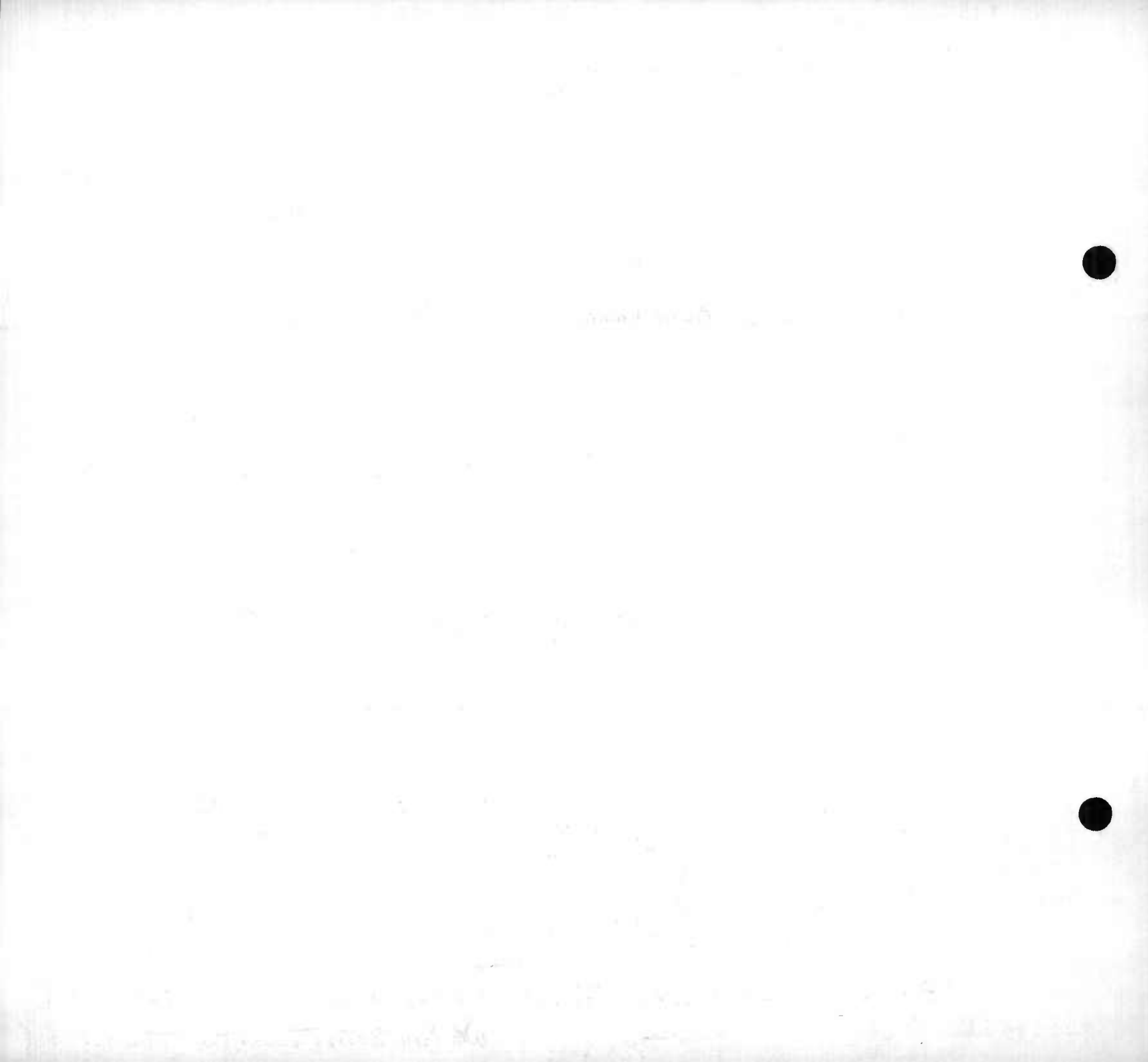
| | | | | | |
|--|--|---|--|---|--|
| 0-480 71 0832 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0832 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Winifred OLEY</i> | | 2. DATE AND HOUR OF DEATH <i>Jan 24, 1971</i> | | 7:05 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Garbar View Nursing Home</i> <i>1213 Light St</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>A.A.</i> | | 5210 | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Garbar View Nursing Home</i> | | C. CITY OR TOWN <i>Annapolis Md</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <i>206 King George St</i> | | 8. DATE OF BIRTH <i>9/15/88</i> | | 9. AGE (in years last birthday) <i>82</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Teaching</i> | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | |
| 13. FATHER'S NAME <i>Walter Oley</i> | | 14. MOTHER'S MAIDEN NAME <i>Ann Bassant</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>170-22-9242</i> | | 17. INFORMANT <i>Mrs Carl McMillen</i> | |
| 18. <i>1/24</i> | | CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>arteriosclerotic Cardio Vascular Disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Brain Syndrome</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Rheumatoid Arthritis</i> (C) | | ADDRESS <i>206 King George St Annapolis Md</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (i) (this hospital) attended the deceased from <i>2-8</i> 19 <i>69</i> to <i>1-24</i> 19 <i>71</i> that (u) (we) last saw the deceased alive on <i>1-24</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Colando V. How MD</i> | | | | 23B. DATE SIGNED <i>1-25-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i> | | 24B. DATE <i>Jan. 25, 71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Uedar Hill Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1971</i> | | | |
| 25B. NAME OF REGISTRAR <i>Colando V. How MD</i> | | 25C. FUNERAL DIRECTOR <i>Hopping Funeral Home, Annapolis, Maryland</i> | | | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0833 | |
|---|--------------------------|--|----------------------------------|---|--|
| F-435 71 0833 | | | | REG. NO. 71 0833 | |
| 1. NAME OF DECEASED (Type or Print) <u>ASA - BESSIE CAROLINE</u> <u>Fielding, Mrs Elizabeth G.</u> | | 2. DATE AND HOUR OF DEATH <u>1-23-71</u> <u>6:15</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Towson</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>34 Wilfred Court</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-6-1886</u> | 9. AGE (In years last birthday) <u>84</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u> | |
| 13. FATHER'S NAME <u>John Gentrum</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Biddison</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-48-6352</u> | | 17. INFORMANT <u>Keswick Records</u> ADDRESS | |
| 18. <u>485 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| (B) _____ DUE TO, OR AS A CONSEQUENCE OF: | | (C) _____ DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Encephalomalacia secondary to cerebral arteriosclerosis</u> | | | | <u>3 years</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>1/12/70</u> 19__ to <u>1/23/71</u> 19__ that (2) (we) last saw the deceased alive on <u>1/23/71</u> 19__ and that in (my) <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W.B. Daniels, Jr.</u> | | 23B. DATE SIGNED <u>1/25/71</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) <u>W. B. Daniels, Jr. MD</u> | | 23D. ADDRESS <u>Keswick, 700 W. 40th Baltimore Md, 21211</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>1-27-71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Pikesville Balt- Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>W. B. Daniels, Jr. MD</u> | | 25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson Inc. Towson Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| C-620 | | 71 0834 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. | | 71 0834 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Grace Cross</i> | | | | 2. DATE AND HOUR OF DEATH <i>1-23-71</i> <i>2:45 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balto.</i> | | | | 5. CITY OR TOWN <i>Sparrows Pt Md</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Harbor View Nursing Home</i> <i>70 1213 Light St</i> | | | | E. STREET AND NUMBER <i>7419 Bayfront Ave</i> | | | | | | | |
| 5. SEX <i>F</i> | | 6. RACE <i>W</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>9/11/01</i> | | 9. AGE (in years lost birthday) <i>69</i> | | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <i>Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Chas. A. Plummer</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Grace E. Reuschling</i> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>214-56-5274</i> | | 17. INFORMANT <i>Sister</i> | | | | ADDRESS <i>7419 Bayfront Rd.</i> | |
| 18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours.</i> | | | |
| | | | | (B) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF: | | | | <i>1 week</i> | | | |
| | | | | (C) <i>A.S. P.V. Disease</i> | | | | <i>?</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Epilepsy</i> | | | | | | | | <i>?</i> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/27</i> 19 <i>70</i> to <i>1/17</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>1/17</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>Joseph S. Blum</i> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <i>1/26/71</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM</i> | | | | 23D. ADDRESS <i>1117 N CALVERT ST</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/27/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1971</i> | | | | 25B. NAME OF REGISTRAR <i>Blum</i> | | | | 25C. FUNERAL DIRECTOR <i>Donovan Funeral Home</i> | | | |
| | | | | ADDRESS <i>-3818 Roland Ave.</i> | | | | | | | |

R-240

71

0835

BALTIMORE CITY HEALTH DEPARTMENT

71

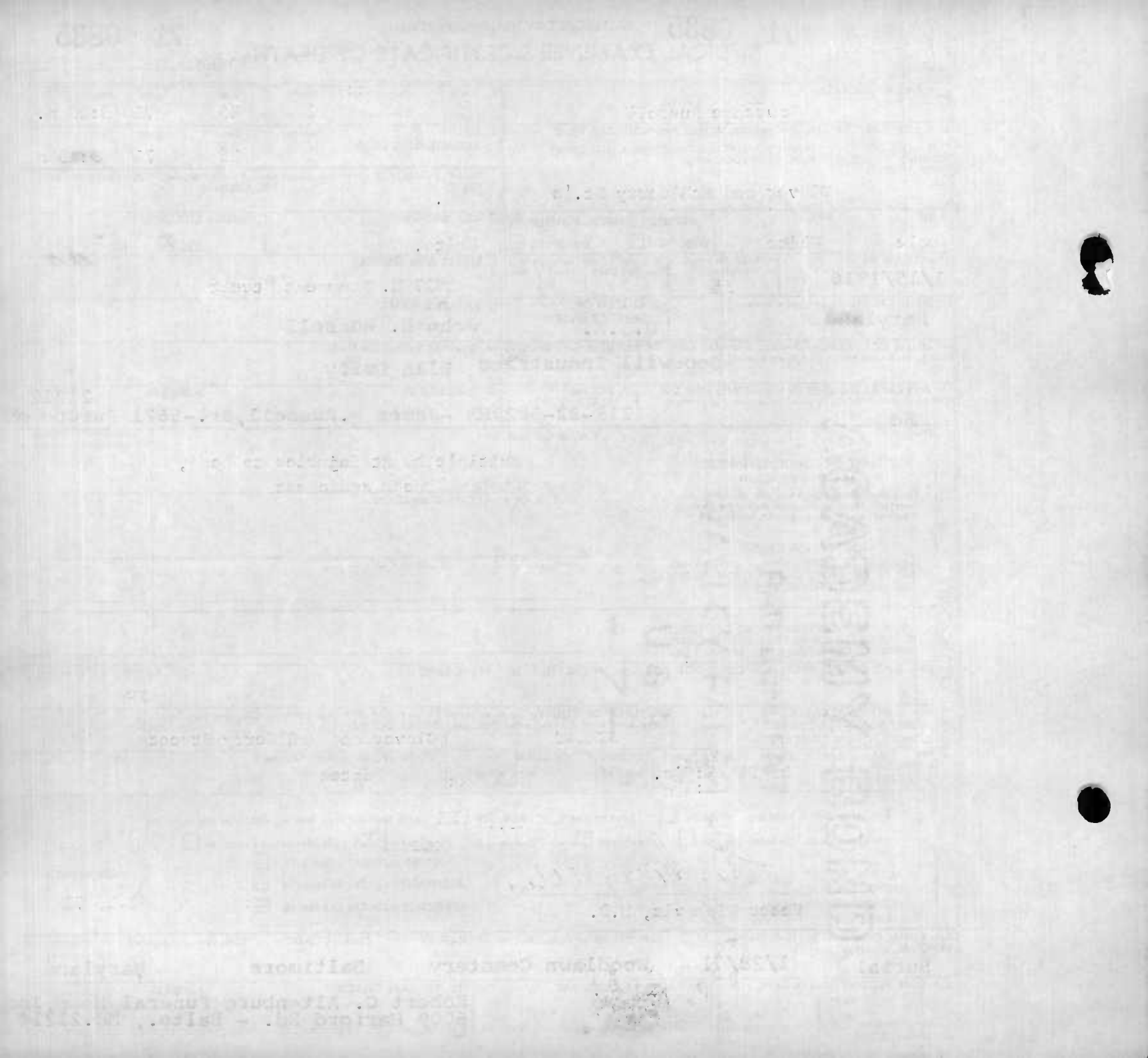
0835

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

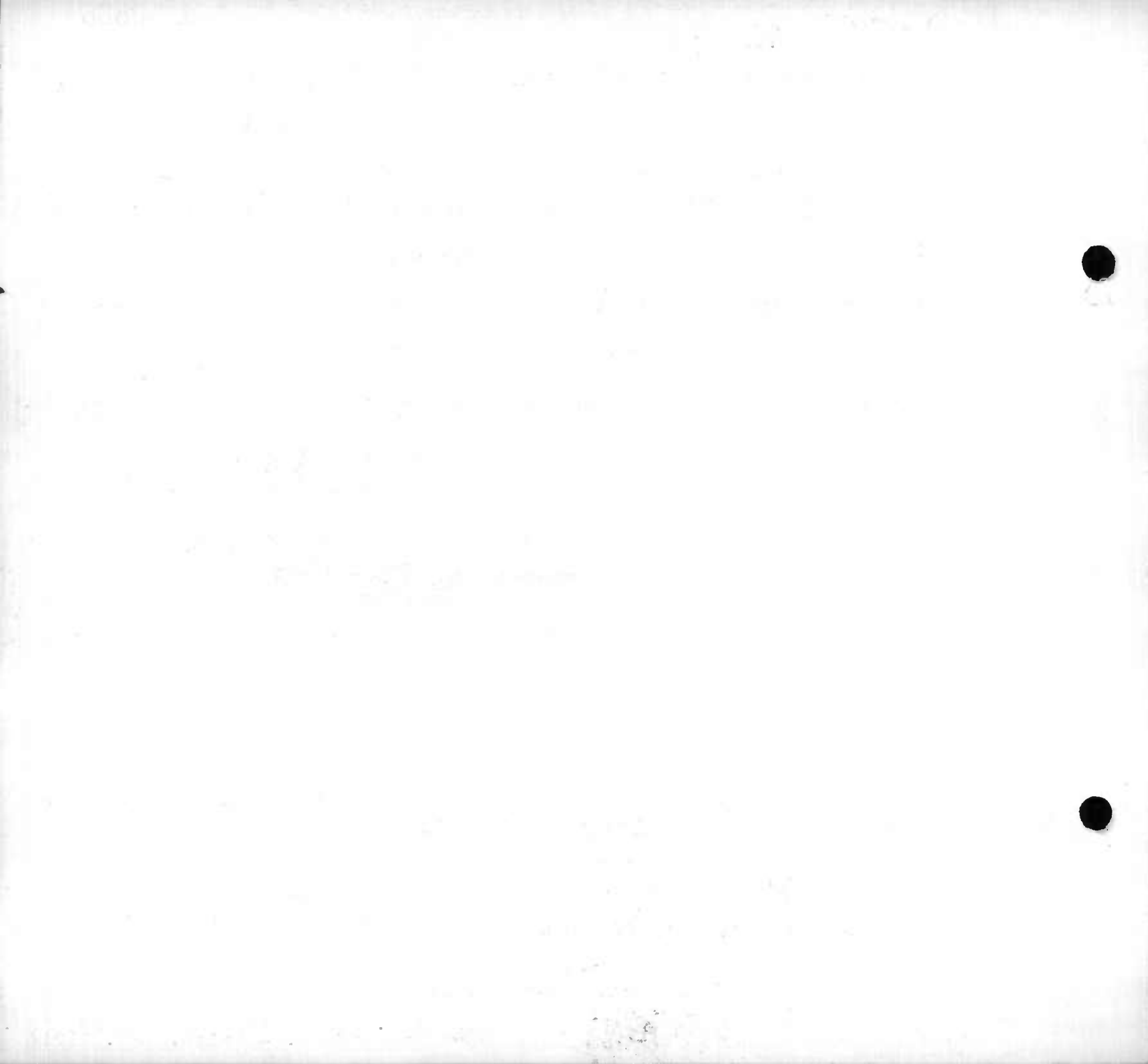
| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Lawrence Russell | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 25 71 5:25 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Glover and McElderry St.'s | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 25 71 5:25 a.m. | |
| 6. SEX male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1/15/1916 | | 10. AGE (In years lost birthday) 55 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Goodwill Industries | | 15. MOTHER'S MAIDEN NAME Ella Duffy | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 219-32-6829 | |
| 18. INFORMANT James W. Russell, Sr. | | ADDRESS 21212 5621 Purdue Av | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple blunt injuries to head, (A) IMMEDIATE CAUSE neck and chest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET Glover and McElderry Streets | |
| 22D. TIME OF INJURY (APPROX.) 1 25 71 5:25 a.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> Beaten | |
| 22F. HOW DID INJURY OCCUR? Beaten | | 21. AUTOPSY? (Yes or No) yes | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/25/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert C. Altenburg | |
| 25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc 6009 Harford Rd. - Balto., Md. | | 25D. ADDRESS 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

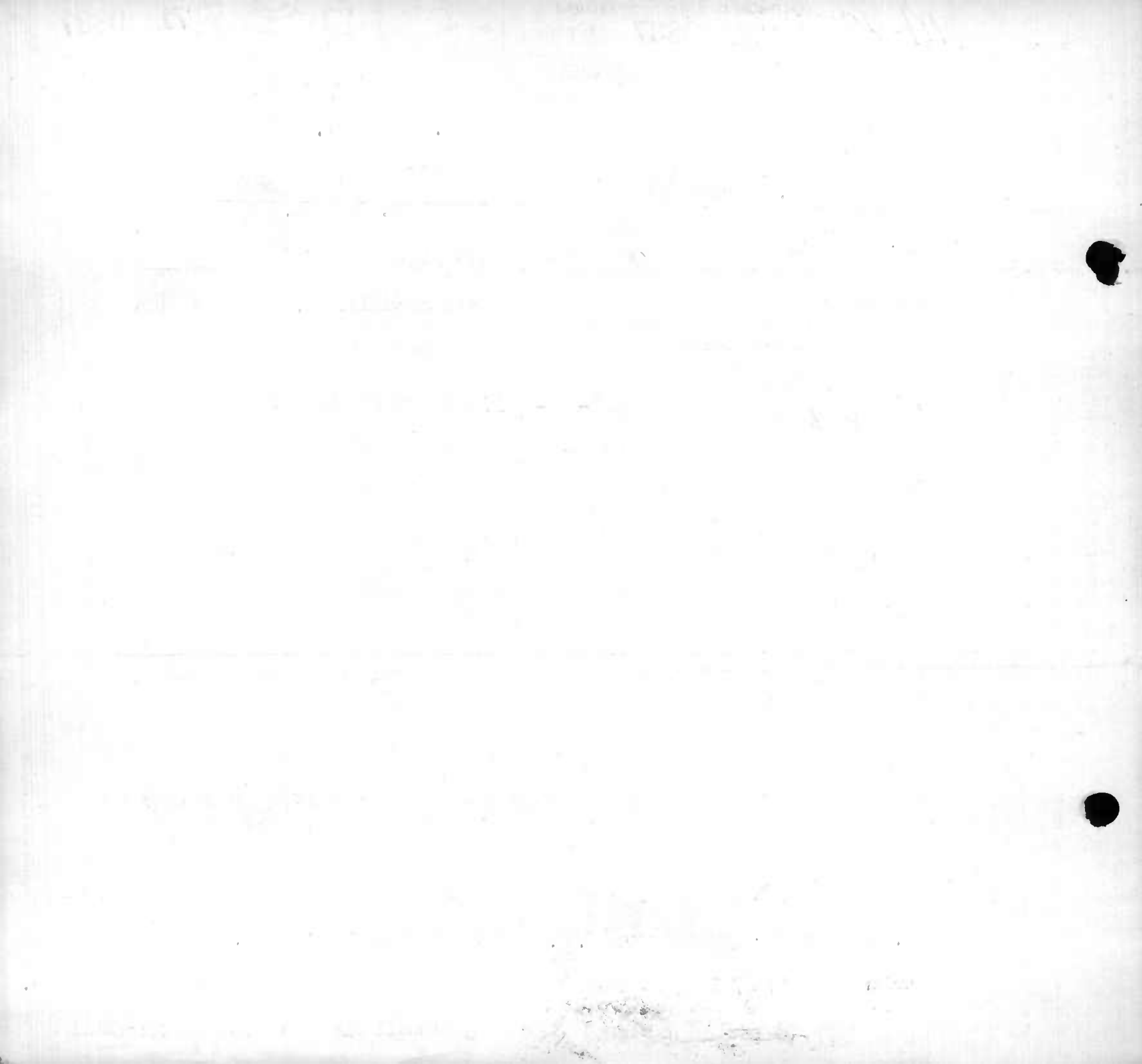
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0836 | | REG. NO. | |
|--|------------------|--|--|---|--|--|--|
| BIRTH NO. <u>1-515</u> | | | | 71 0836 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>MARGARET DONOVAN</u> | | | | 2. DATE AND HOUR OF DEATH <u>1-25-71</u> <u>5:15 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME AND</u> <u>35 HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>USA</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1127 E. Bolvedere Ave (12)</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/27/09</u> | 9. AGE (in years last birthday) <u>61</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Paul Donovan</u> |
| 14. MOTHER'S MAIDEN NAME <u>Mary Quigley</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>235-20-3700</u> | | 17. INFORMANT <u>Ignita Hove</u> ADDRESS <u>1127 E. Bolvedere Ave (12)</u> |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <u>Electrolyte Imbalance</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe Hypertension</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CA of cancer</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sev. days</u> <u>Sev. weeks</u> <u>none</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 31</u> 19 <u>70</u> to <u>Jan. 25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Jan 25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Colando Mendez</u> DEGREE | | | | 23B. DATE SIGNED <u>1-25-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>COLANDO MENDOZA, M.D.</u> DEGREE | |
| 23D. ADDRESS <u>100 N. Broadway St. Balto., MD. 611</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/27/71</u> | |
| 24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u> | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | |
| 25B. NAME OF REGISTRAR <u>Robert C. Altenburg</u> | | | | 25C. FUNERAL DIRECTOR <u>Robert C. Altenburg</u> | | 25D. ADDRESS <u>6099 Harford Rd. - Balto., Md. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

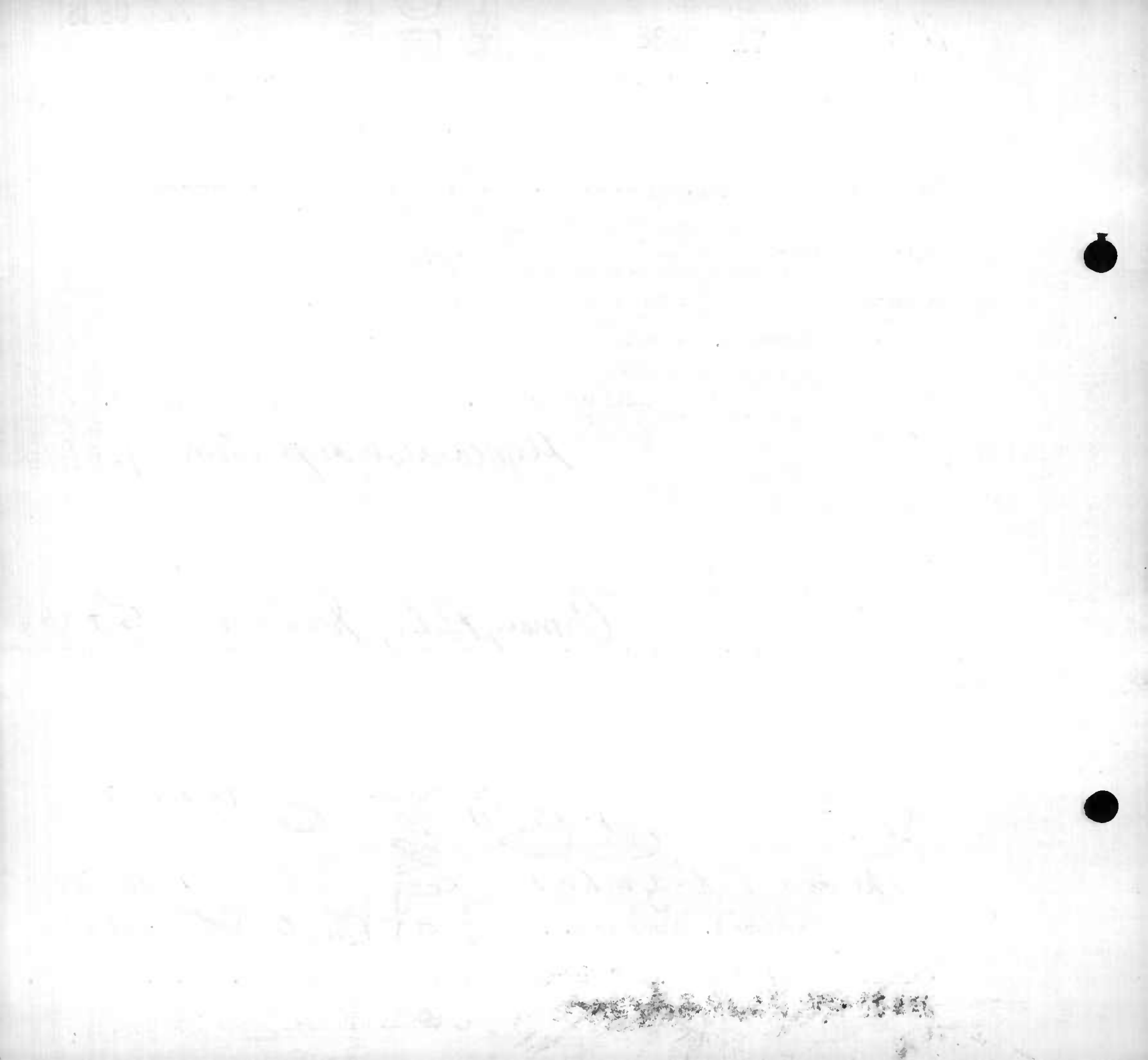
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0837 | |
|--|---------|--|---|--|---|
| 17-425 71 0837 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Margaret Mullikin | | 1/23/1971 12 ²⁵ A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 90 Long Green Nursing Home 115 E. Melrose Ave | | | Md. Balto. 1202 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 3501 St. Paul St. | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. Under 1 Yr. Months Days |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 7/18/1885 | 85 | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Hoemaker | | | | Davidsonville, Md. | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Lemmon Beall | | | USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | 212-01-1611 | | Miss Mary Mullikin 220 Homewood Terrace |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 1978 I | | | Carcinoma of the Liver. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 29 1966 to January 23 1971, that (I) (we) last saw the deceased alive on January 17 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| W. Grafton Hersperger | | | | January 24, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| W. GRAFTON HERSPERGER M.D. | | | | 4206 CHARLCOTE RD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1/25/71 | | Woodlawn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Woodlawn Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 28 1971 | | R. S. C. [Signature] | | Mitchell Medefield Home 6500 York Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|--|--|--|--|---|---|--|
| 71 0838 CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 71 0838 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Eugene E. McKenna | | | | | 2. DATE AND HOUR OF DEATH January 25, 1971 | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home and Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | | | |
| | | | | | C. CITY OR TOWN Towson | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER 1314 Westellen Rd. | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/23/1914 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | | 10B. KIND OF BUSINESS OR INDUSTRY Automobile | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 13. FATHER'S NAME Eugene E. McKenna | | | | | 14. MOTHER'S MAIDEN NAME Mildred Ellerbrook | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 212 07 8062 | | 17. INFORMANT ADDRESS J. Albert McKenna 1314 Westellen Rd. | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cronary Artery Disease | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-62 19 to 1-25-71 19, that (I) (we) last saw the deceased alive on 1-25-71 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Theodore T. Niznik Jr | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 1-26-71 | |
| 23C. PHYSICIAN'S NAME (Type) Theodore T. Niznik Jr M.D. | | | | | 23D. ADDRESS 4295 Cheek St 21231 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | | | 24D. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | | 25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd. | | | |



| T-600 | | 71 0839 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0839 | |
|--|--|--|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Elaine L. Terry | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 71 7:10 p. | | | |
| 6. SEX female | | | | 7. RACE white | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH OCT. 27TH 1920 | | | | 10. AGE (In years lost birthday) 50 | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1201 | |
| 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | C. CITY OR TOWN Baltimore | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | | | 14B. KIND OF BUSINESS OR INDUSTRY | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 17. SOCIAL SECURITY NO. 218-12-4876 | | 13. FATHER'S NAME CLIFTON I. LOWE | |
| 18. INFORMANT Mr. DONALD G. TERRY (HUSBAND) | | | | 15. MOTHER'S MAIDEN NAME ELSIE MITCHELL | | ADDRESS | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION 2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3800 Canterbury Rd. | |
| 22D. TIME OF INJURY (APPROX.) Month Day Year Hour 1 18 71 6:50p | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? fell or jumped from third story window | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> 1/19/71 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT | | 24B. DATE 1/22/71 | | 24C. NAME OF CEMETERY or CREMATORY LORRAINE MAS. | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME | | ADDRESS 6500 York Rd. 21212 | |

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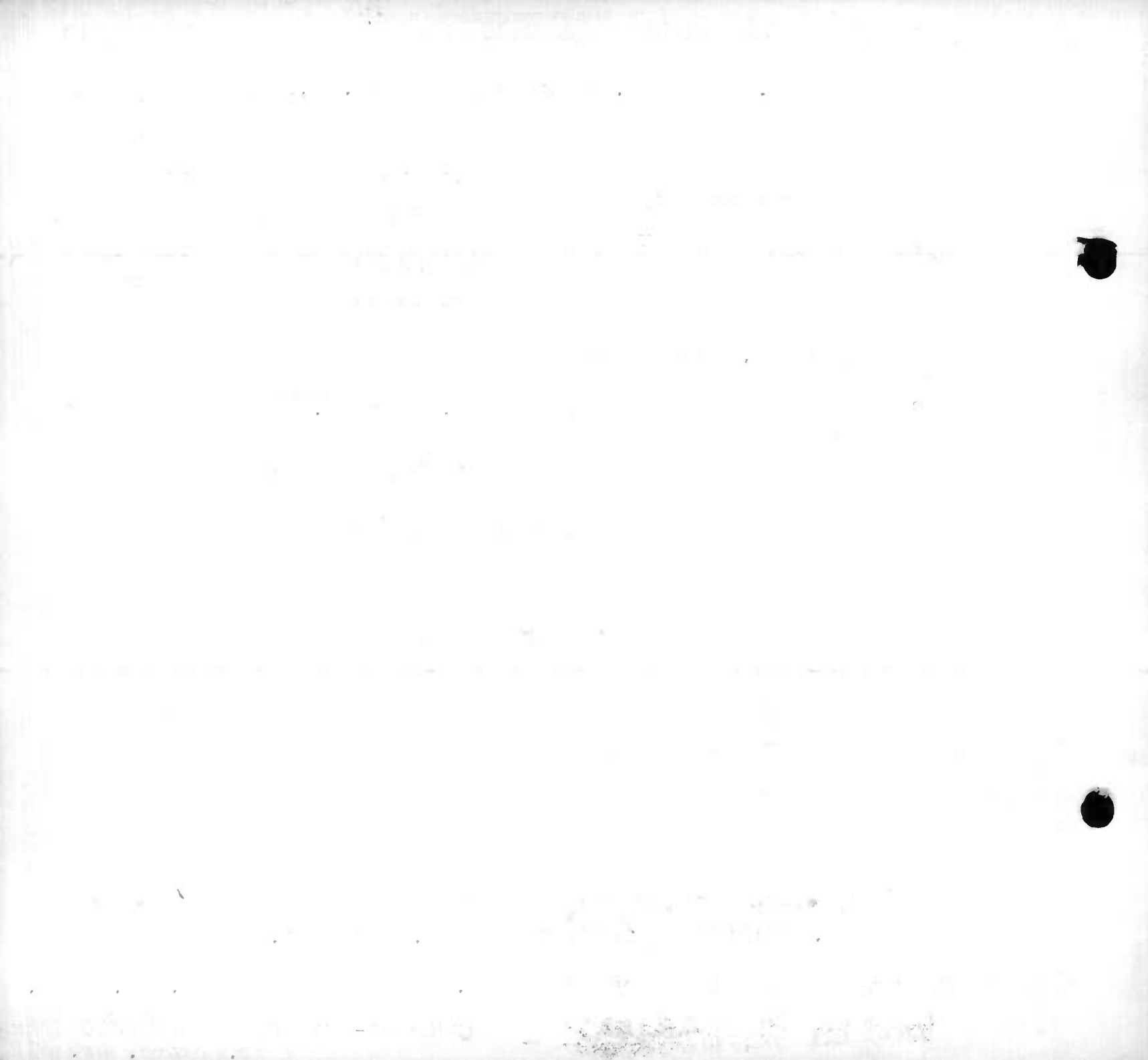
71 0830

71 0830

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| R-263 | | 71 0840 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0840 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) DR. EDWARD H. RICHARDSON | | | |
| 2. DATE AND HOUR OF DEATH JAN. 15, 1971 | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 00 3 WHITFIELD ROAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2711 | | | | 5. SEX MALE 6. RACE WHITE | | | |
| C. CITY OR TOWN BALTIMORE | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 3 WHITFIELD ROAD | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 11/13/1877 | | | | 9. AGE (In years lost birthday) 93 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SURGEON | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME WILLIAM P. RICHARDSON | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-43-4306 J | | | |
| 17. INFORMANT MRS. EMILY G. RICHARDSON | | | | ADDRESS SAME | | | |
| 18. 431.9 I 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypertension | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.] | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Charles Wainwright | | | | 23B. DATE SIGNED 1/16/71 | | 23C. PHYSICIAN'S NAME (Type) DR. CHARLES WAINWRIGHT | |
| 23D. ADDRESS 9 E. CHASE ST. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/18/71 | | 24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM. | | 24D. LOCATION (City, town, or county) (State) BALTO. Co. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert J. [illegible] | | 25C. FUNERAL DIRECTOR NOTHELL-NIEDEFELD HOME | | ADDRESS 6500 YORK RD. BALTO. MD. 21221 | |



H-630

71

0841

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

0841

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Emma J. Hurd | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 24 71 8:35 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 House in Pines | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 24 71 8:35 p.m. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 14 Sept. 1879 | | 10. AGE (In years lost birthday) 91 | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY Homekeeping | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 17. SOCIAL SECURITY NO. 008-20-3225D | |
| 18. INFORMANT W. Johnson Hurd | | ADDRESS 21206 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fractured hip and ribs OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Manchester Depot, Vermont | | 22D. TIME OF INJURY (APPROX.) 12 24 70 unk. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subject fell | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| DATE SIGNED 1/25/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-26-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Hill Side Cemetery | | 24D. LOCATION (City, town, or county) (State) Castleton Vt. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Lassahn Funeral Home | |
| 25C. FUNERAL DIRECTOR Lassahn Funeral Home | | ADDRESS 7401 Belair Rd. 21236 | |

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ACADEMY

B-350 71 0842

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0842

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Raymond W. BOUTON | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 24, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 24, 1971 12:32 A M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 28 Dec 15 | | 10. AGE (In years last birthday) 55 | |
| 11. BIRTHPLACE (State or foreign country) New York (Astoria) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor | | 14B. KIND OF BUSINESS OR INDUSTRY Self Employed | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | 17. SOCIAL SECURITY NO. 055-14-1670 | |
| 18. INFORMANT Mrs. Raymond Bouton | | ADDRESS 21206 3912 E. Northern Pkwy. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 27 Jan 71 | |
| 24C. NAME of CEMETERY or CREMATORY Gardens Of Faith Cemetery | | 24D. LOCATION (City, town, or county) (State) Overlea Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Lassahn Funeral Home | |
| 25C. FUNERAL DIRECTOR Lassahn Funeral Home | | ADDRESS 7401 Belair Rd. 21236 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------|---|------------------|--|-----------------------------|
| B-256 | | 71 0843 | | 71 0843 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| SYLVAN BUCKNER | | 1-25-71 7:25 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42 | | A. STATE B. COUNTY | | | |
| | | BALTIMORE, Md. 5300 | | | |
| C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | E. STREET AND NUMBER 4204 COLONIAL ROAD | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. UNDER 1 Yr. Months Days |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11-30-1902 | 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| CAB DRIVER | | SUN CAB CO. | | BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME ISADORE BUCKNER | | 14. MOTHER'S MAIDEN NAME LENA ? | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216-03-0288 | | 17. INFORMANT MRS. LILLIE BUCKNER, 4204 COLONIAL ROAD #8 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE PRIMARY Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (B) Co pulmonale. DUE TO, OR AS A CONSEQUENCE OF: (C) Pulmonary edema + ? myocardial infarction. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-22 1971 to 1-25 1971 that (I) (we) last saw the deceased alive on 1-25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Shuman, M.D. | | | | 23B. DATE SIGNED 1-25-71 | |
| 23C. PHYSICIAN'S NAME (Type) J. SHUMAN, M.D. | | | | 23D. ADDRESS Sinai Hospital of Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 1-26-71 | | CHIZUK AMUNO (ARLINGTON) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 28 1971 | | [Signature] | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |
| 25D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | | | |

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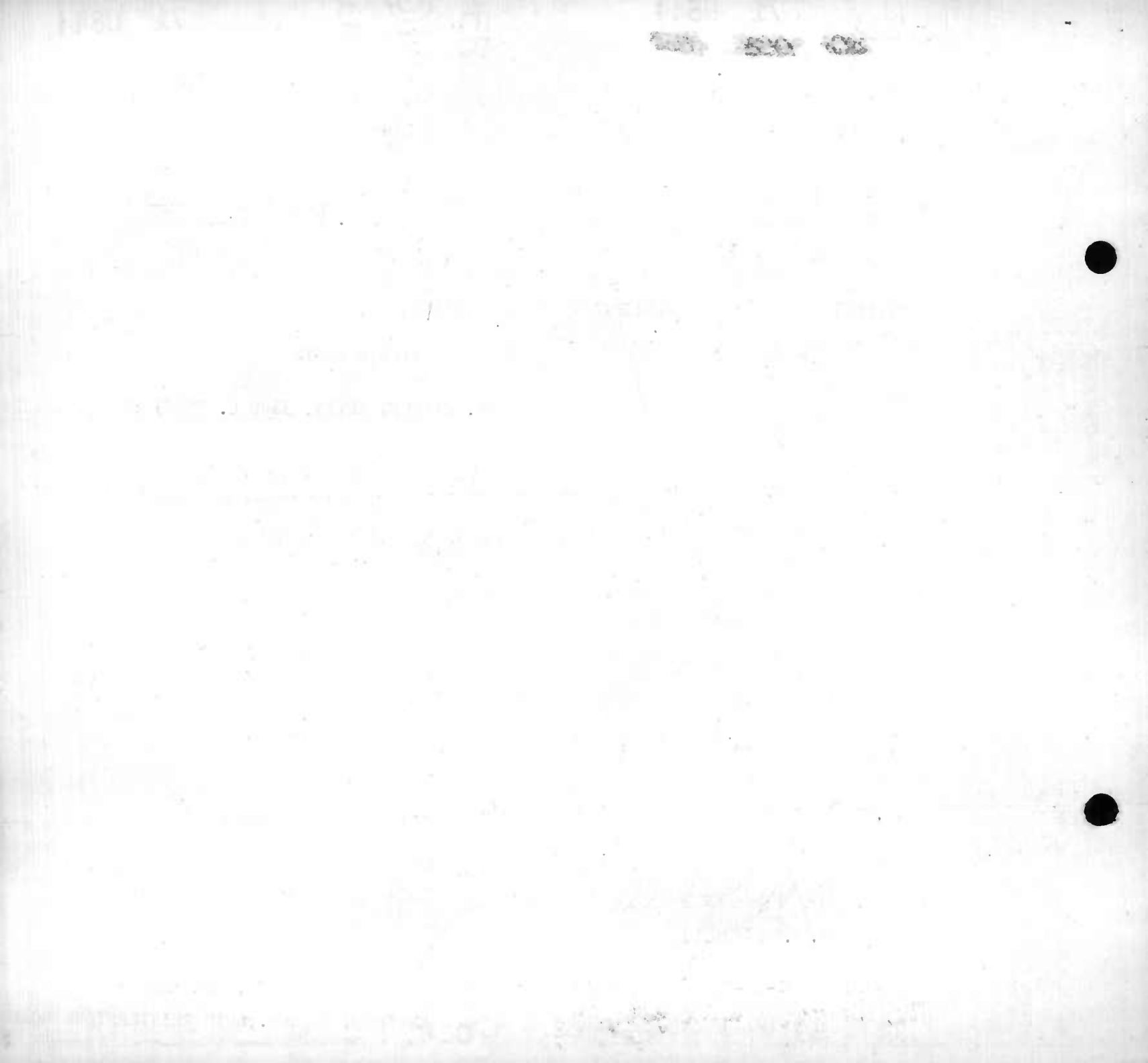
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0844 | |
|---|--|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) JEROME D. LEVIN | | 2. DATE AND HOUR OF DEATH 1/23/71 7 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: 3 Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3309 E. PRATT STREET | | | |
| 5. SEX male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-2-50 | 9. AGE (In years lost birthday) 21 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | | 10B. KIND OF BUSINESS OR INDUSTRY COLLEGE | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME Gilbert Levin | | 14. MOTHER'S MAIDEN NAME TILLIE DUBIN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. GILBERT LEVIN, 3309 E. PRATT STREET #21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE METABOLIC ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF: (B) REGIONAL ENTERITIS DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/1/71 19 71 to 1/23 19 71 that (I) (we) last saw the deceased alive on 1/23 19 71 and that in (my) (our) opinion death occurred on the date 1/23 19 71 and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W.H. Mitchell | | | | 23B. DATE SIGNED 1/23/71 | |
| 23C. PHYSICIAN'S NAME (Type) W.H. MITCHELL | | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-26-71 | | 24C. NAME OF CEMETERY or CREMATORY MEADOW RIDGE MEMORIAL | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



71 0845 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **71 0845**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **ALBERT FIEDLER SR.**

2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour M.
 3. DATE PRONOUNCED DEAD Month Day Year Hour M.
1 27 1971 5:05 a

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 St. Agnes Hospital 1-29-71

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
 A. STATE **Md.** B. COUNTY **BALTO 520**

6. SEX **male** 7. RACE **white** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN **Balto.** D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH **6/16/09** 10. AGE (In years last birthday) **61** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
 E. STREET AND NUMBER **720 Meadow Brook Rd.**

11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.** 13. FATHER'S NAME **OTTO P. FIEDLER**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **FLORIST** 14B. KIND OF BUSINESS OR INDUSTRY **FLORIST** 15. MOTHER'S MAIDEN NAME **MINNIE DAGGART**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 17. SOCIAL SECURITY NO. **215-09-1992** 18. INFORMANT **LEONA FIEDLER** ADDRESS

19. **412.41** CAUSE OF DEATH **Arteriosclerotic cardiovascular disease** APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION **2** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
 21. AUTOPSY? (Yes or No) **yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
 ACTUAL SIGNATURE **Ronald N. Kornblum** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
 EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☒ 1-27-71
 ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **BURIAL** 24B. DATE **1/30/71** 24C. NAME OF CEMETERY or CREMATORY **CLEN HAVEN** 24D. LOCATION (City, town, or county) (State) **A.A. Co Md.**

25A. DATE REC'D BY HEALTH DEPT. **JAN 28 1971** 25B. NAME OF REGISTRAR **Charles E. ...** 25C. FUNERAL DIRECTOR **MACNABB** ADDRESS **21228**

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|--------------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> 71 0846 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> T-200 REG. NO. 71 0846 </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ADNA MARTHA TAEIS | | JAN. 26, 1971 5:50 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOULD NURSING HOME DECAIR RD | | | | A. STATE | |
| | | | | B. COUNTY | |
| | | | | C. CITY OR TOWN | |
| | | | | D. INSIDE CITY LIMITS? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | |
| | | | | 8014 NEIGHBORS AVE | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| F | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8/28/79 | 91 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| H W. | | | | PA. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| THOMAS FITZPATRICK | | | CATHERINE SALTSEIVER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | 212-26-9763 | | JEROME WISE ABOVE |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| 412.4 I | | Anteriosclerotic C-V disease | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) Cerebrovascular insufficiency | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Peripheral vascular insufficiency | | | |
| II | | Infected decubiti (arteriosclerotic) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 9 1970 to Jan. 26 1971, that (I) (we) last saw the deceased alive on Jan. 25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| H.V. Harbold M.D. | | | | Jan. 26, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| H.V. HARBOLD M.D. | | | | 4706 Harford Road 21214 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 1/29/71 | | SACRED HEART | |
| 24D. LOCATION (City, town, or county) | | 24E. NAME of REGISTRAR | | 24F. FUNERAL DIRECTOR ADDRESS | |
| BALTO. M.D. | | | | 300 Race Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | |
| JAN 28 1971 | | | | | |

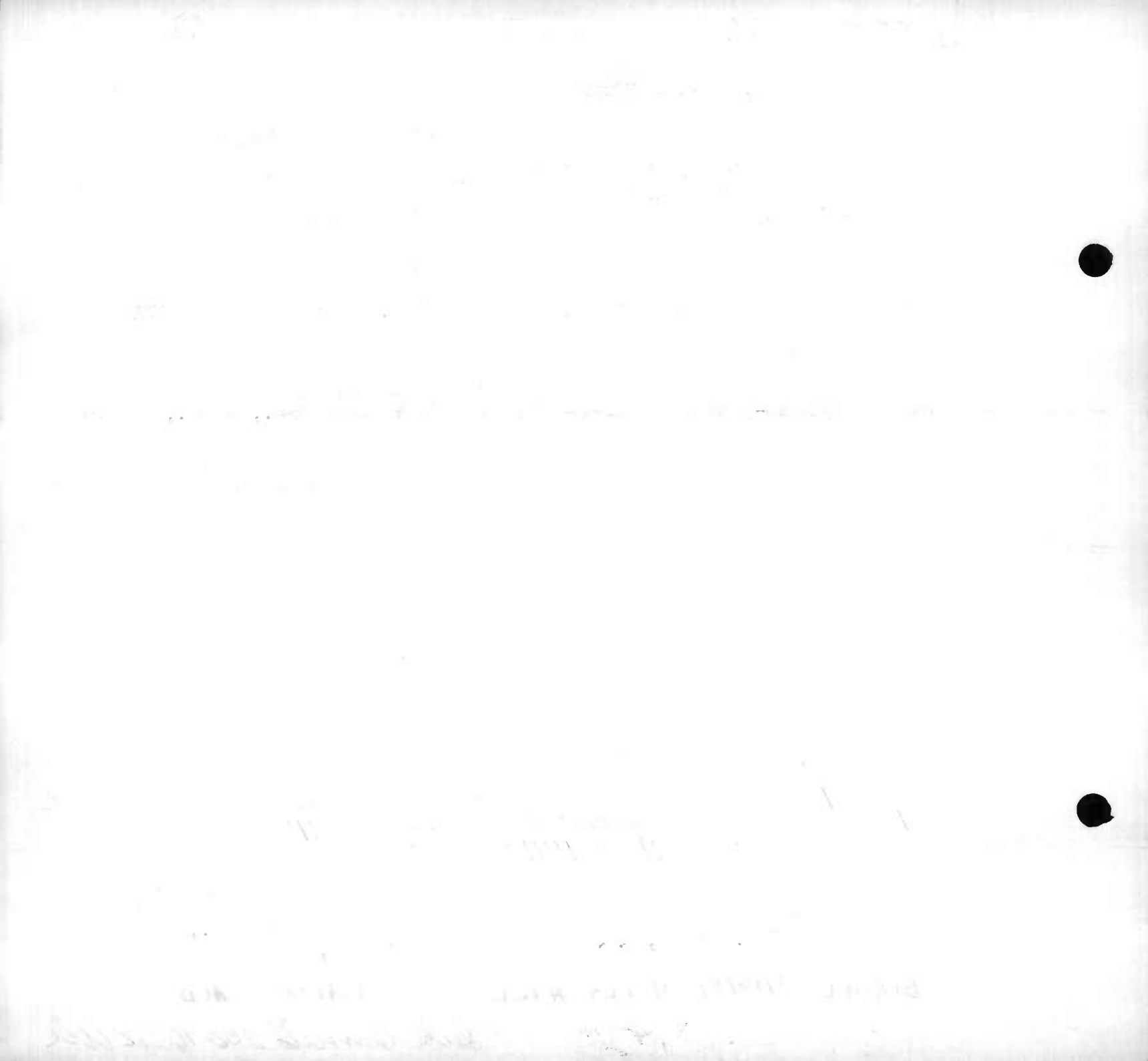
Infected denture (retained)
Dental procedure
Cervical occlusion
Cervical occlusion
Cervical occlusion

July 20 1955

H. V. H. B. R. O. D. M. D. 4505 Harbor Road
H. V. H. B. R. O. D. M. D. 4505 Harbor Road

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | 71 0847 | |
|---|-------------------------|---|------------------------------------|--|---|---|--|
| 1-525 71 0847 | | | | CERTIFICATE OF DEATH | | 71 0847 | |
| BIRTH NO. <u>1-525</u> | | | | 2. DATE AND HOUR OF DEATH <u>1/25/71</u> <u>2:55</u> A. M. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>JENKINS, Clarence Edward</u> | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>13 Blister Street</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/13/87</u> | 9. AGE (In years last birthday) <u>84</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min. | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Auto (Martins)</u> | | | |
| 13. FATHER'S NAME <u>Jacob Jenkins</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lenora Barnes</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>5/17/18-3/26/19</u> | | | | 16. SOCIAL SECURITY NO. <u>212-03-3936</u> | | 17. INFORMANT <u>VA Hospital Records</u> <u>3900 Loch Raven Blvd., Balto., Md 21218</u> | |
| 18. <u>450 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Multiple pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF: <u>with infarction to lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>None</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>January 7th</u> 19 <u>71</u> to <u>January 25th</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>January 25th</u> 19 <u>71</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Donald H. Hooker</u> DONALD H. HOOKER, M.D. | | | | 23B. DATE SIGNED <u>1/26/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Donald H. Hooker</u> DEGREE | |
| 23D. ADDRESS <u>3900 Loch Raven Blvd.,</u> <u>Baltimore, Maryland 21218</u> | | | | 23E. NAME OF REGISTRAR <u>John E. [unclear]</u> | | 23F. FUNERAL DIRECTOR <u>John E. [unclear]</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1/28/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>HOLLY HILL</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u> | |
| 25A. DATE RECD BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>John E. [unclear]</u> | | 25C. FUNERAL DIRECTOR <u>John E. [unclear]</u> | | 25D. ADDRESS <u>3900 Loch Raven Blvd.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|---|--|---|---|---|--|--|
| BIRTH NO. <u>H-425</u> | | | | | REG. NO. <u>71 0848</u> | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>GUSSIE HOLCOMB</u> | | | | | 2. DATE AND HOUR OF DEATH <u>1-26-71</u> <u>1:30 A.M.</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2716</u> | | | | |
| | | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER <u>3310 VIRGINIA AVE</u> | | | | |
| 5. SEX <u>FEM</u> | | 6. RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-25-93</u> | | 9. AGE (in years last birthday) <u>77</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Max</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Fannie</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Hoop Clark</u> | | | |
| 18. <u>4124 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH <u>ACCIDENT</u> (A) IMMEDIATE CAUSE <u>CEREBRO VASCULAR</u> DUE TO, OR AS A CONSEQUENCE OF: <u>DISEASE</u> (B) <u>ATHEROSCLEROTIC CARDIOVASCULAR</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YEARS</u> | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> 19 <u>71</u> to <u>1-26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1-26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>1-26-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. BEN DRZANSKI MD</u> | | | | | | 23D. ADDRESS <u>50 SINAI HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>1/27/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Anshe Neuser</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Balto Md</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | | 25C. FUNERAL DIRECTOR <u>[Signature]</u> | | ADDRESS <u>9610 Rustenburg</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0849 | |
|---|---------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | X | |
| BIRTH NO. 17-214 | | 1. NAME OF DECEASED (Type or Print) NANCY D. MCPHAIL | | 2. DATE AND HOUR OF DEATH 1/25/71 7:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PA B. COUNTY York | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 45 GOOD SAMARITAN HOSPITAL | | | C. CITY OR TOWN NEW FREEDOM | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| FULL NAME OF HOSPITAL OR INSTITUTION 45 GOOD SAMARITAN HOSPITAL | | | E. STREET AND NUMBER R.D. # 2 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-17-41 | | 9. AGE (In years last birthday) 29 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | 10B. KIND OF BUSINESS OR INDUSTRY Real Estate | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME GEORGE DUTTON | | | 14. MOTHER'S MAIDEN NAME BLEVINS, CORA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 175343409 | | 17. INFORMANT R.M. McPhail, New Freedom RD#2, Pa. 17349 | |
| 18. 746.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) TACHYARRHYTHMIA | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGENITAL HEART DISEASE | | | (B) CONGENITAL HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II | | | (C) | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/19 19 71 to 1/25 19 71 , that (I) (we) last saw the deceased alive on 1/25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael S. Preece M.D. | | | 23B. DATE SIGNED 1/25/71 | | 23C. PHYSICIAN'S NAME (Type) MICHAEL S. PREECE M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1/27/71 | | 24C. NAME OF CEMETERY or CREMATORY Stewartstown Cemetery |
| 24D. LOCATION (City, town, or county) (State) Stewartstown, York Co., Penna. | | | 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | |
| 25B. NAME OF REGISTRAR Robert E. [Signature] | | | 25C. FUNERAL DIRECTOR Robert E. [Signature] | | |
| 25D. ADDRESS Stewartstown, Pa. | | | 25E. ADDRESS Stewartstown, Pa. | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

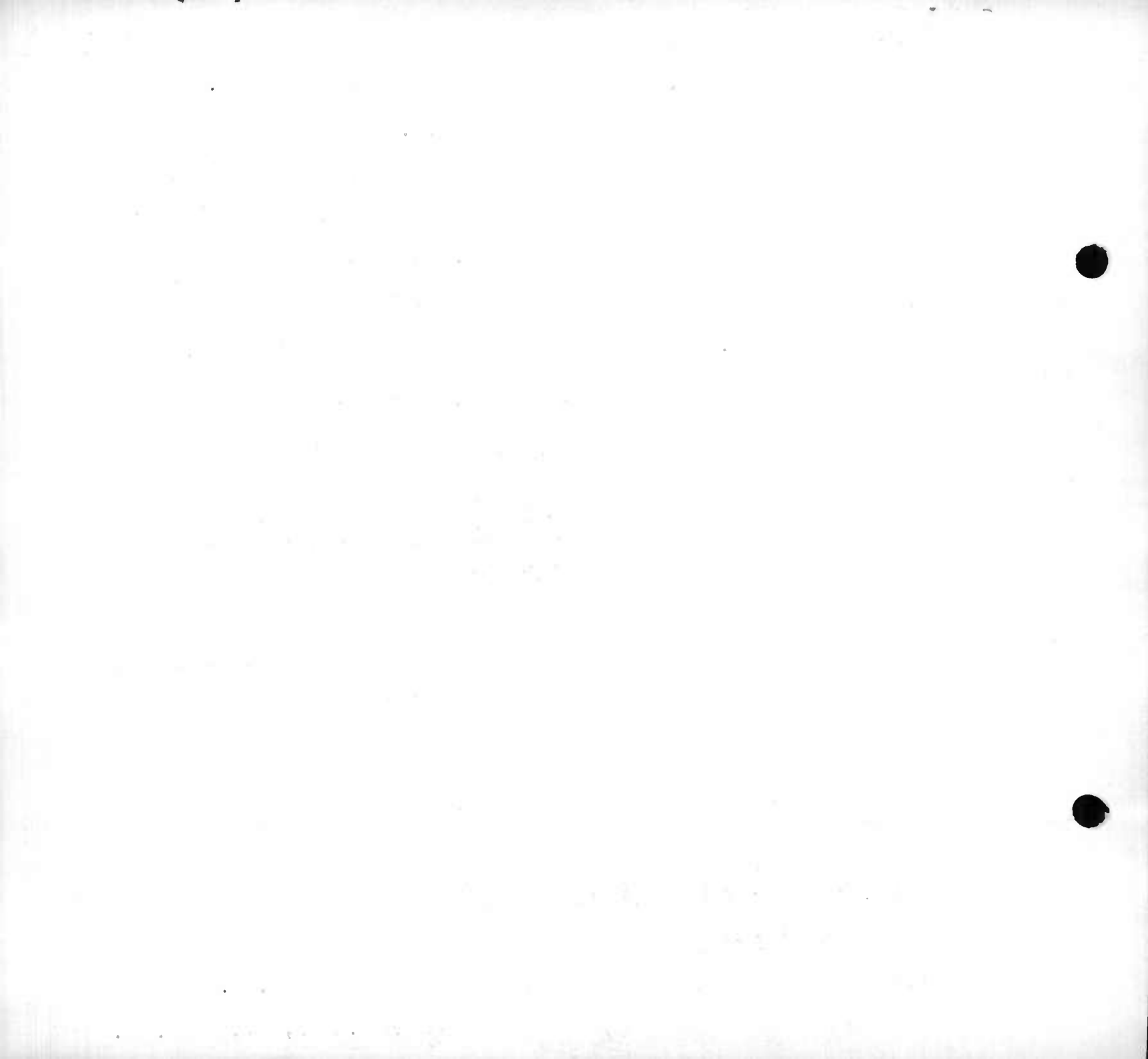
| | | | | | | | |
|---|--|---|--|---|--|--|--|
| <p>BIRTH NO. M-264 71 0850</p> | | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> | | <p>CERTIFICATE OF DEATH</p> | | <p>REG. NO. 71 0850</p> | |
| <p>1. NAME OF DECEASED (Type or Print) MARY V. MCGREAL</p> | | | | <p>2. DATE AND HOUR OF DEATH 1/26/71 9⁵⁰ A.M.</p> | | | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> | | | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MO. B. COUNTY BALTIMORE</p> | | | |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE 42</p> | | | | <p>C. CITY OR TOWN BALTIMORE</p> | | <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> | |
| <p>5. SEX F</p> | | | | <p>6. RACE W</p> | | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | |
| <p>8. DATE OF BIRTH 4/29/19 94.</p> | | | | <p>9. AGE (In years last birthday) 76</p> | | <p>10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.</p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Operator--Bugle Laundry</p> | | | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (State or foreign country) Mass.</p> | |
| <p>12. CITIZEN OF WHAT COUNTRY? USA</p> | | | | <p>13. FATHER'S NAME Daniel J. Minnehan</p> | | | |
| <p>14. MOTHER'S MAIDEN NAME Eva Batz</p> | | | | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p> | | | |
| <p>16. SOCIAL SECURITY NO. 216-30-9999A</p> | | | | <p>17. INFORMANT Miss Evelyn McGreal, 3021 Echodale Avenue</p> | | | |
| <p>18. CAUSE OF DEATH</p> | | | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> | | | |
| <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE</p> | | | | <p>2 days</p> | | | |
| <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | | <p>(B) DUE TO, OR AS A CONSEQUENCE OF: ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Years</p> | | | |
| <p>(C) DUE TO, OR AS A CONSEQUENCE OF: DIABETES, ESSENTIAL HYPERTENSION Years</p> | | | | <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | | |
| <p>19A. DATE OF OPERATION</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) No</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | | <p>22. I certify that (I) (this hospital) attended the deceased from 1-24-19 71 to 1-26-19 71 that (I) (we) last saw the deceased alive on 1-26-19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE Albert L. Menner M.D.</p> | | | | <p>23B. DATE SIGNED 1/26/71.</p> | | <p>23C. PHYSICIAN'S NAME (Type) ALBERT L. MENNER M.D.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | | | <p>24B. DATE 1/29/71.</p> | | <p>24C. NAME OF CEMETERY OR CREMATORY Calvary Cemetery</p> | |
| <p>24D. LOCATION (City, town, or county) (State) Long Island City, New York</p> | | | | <p>25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971</p> | | | |
| <p>25B. NAME OF REGISTRAR Robert E. Faber, Jr.</p> | | | | <p>25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214</p> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

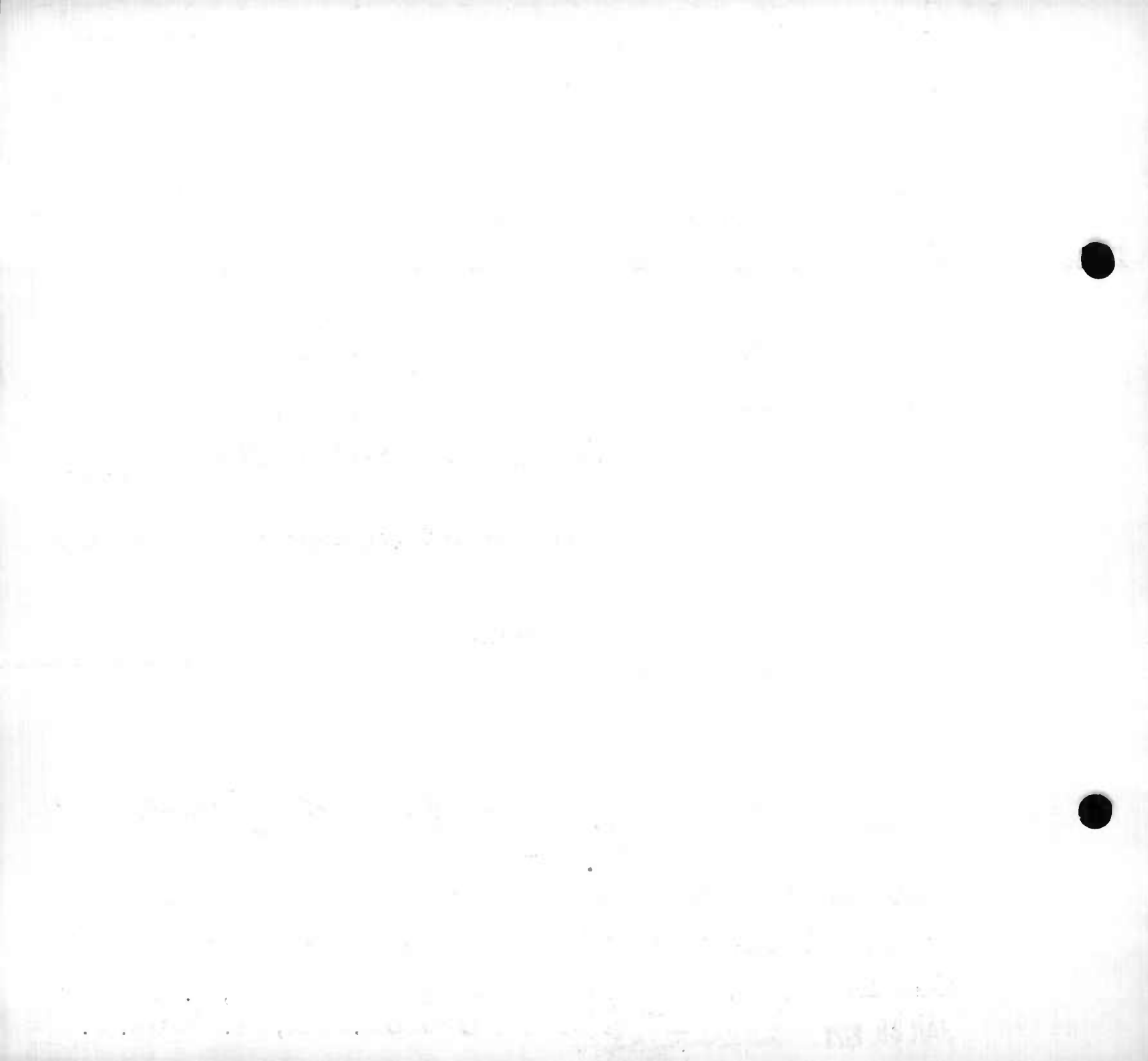
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0851 | |
|---|--|---|--|---|--|
| T-460 71 0851 BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES D. TAYLOR | | 2. DATE AND HOUR OF DEATH January 25, 1971. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3302 Echodale Avenue | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2744 | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH Feb. 17, 1922. | | 9. AGE (In years last birthday) 48 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James W. Taylor | | 14. MOTHER'S MAIDEN NAME Theresa C. Byrnes | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Theresa C. Taylor | |
| 18. 314.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Blondie Pneumonia | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anginal edema (never talked with patient. Finally removed at death.) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 19 to 1-25-71 19 that (I) (we) last saw the deceased alive on 1-23-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. M. Peake M.D. | | | | 23B. DATE SIGNED 1-25-71 | |
| 23C. PHYSICIAN'S NAME (Type) C. M. PEAKE | | | | 23D. ADDRESS 4508 Harford Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0852 | |
|---|----------------------|--|---------------------------------|--|---------------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. <i>71 0852</i> | | NAME OF DECEASED <i>Mrs. Sue C. Paul</i> | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH <i>January 22, 1971 11:30 A.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>Maryland</i> | | B. COUNTY <i>1102</i> | |
| <i>Anderson Nursing Home</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| <i>3604 Mohawk Ave. Baltimore, Md.</i> | | E. STREET AND NUMBER <i>22 East Madison Street</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9-26-80</i> | 9. AGE (In years last birthday) <i>90 yrs.</i> | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| <i>Housewife</i> | | | | <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Joshua Childs</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah J. Forsythe</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>213-48-3193</i> | | 17. INFORMANT <i>Aldine M. Prigion-3604 Mohawk Ave.</i> | |
| <i>No</i> | | | | ADDRESS <i>21207</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| <i>4-33-9 I</i> | | <i>Cerebro-vascular thrombosis</i> | | <i>1 day</i> | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) <i>Cerebral arteriosclerosis</i> | | <i>10 years</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | <i>none</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 21, 1968</i> to <i>Jan. 22, 1971</i> that (I) (we) last saw the deceased alive on <i>Jan. 21, 1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Marvin Goldstein, M.D.</i> | | | | 23B. DATE SIGNED <i>1/22/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MARVIN GOLDSTEIN, M.D.</i> | | | | 23D. ADDRESS <i>6001 PARK HEIGHTS AVE. BALTO. MD.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| <i>Cremation</i> | | <i>1/26/71</i> | | <i>Greenmount Crematory</i> | |
| | | | | <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> | |
| | | | | <i>Balto. Md.</i> | |



B-650

71 0853

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0853

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Robert Brown | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 22 71 10:20 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH April 26, 1937 | | 10. AGE (In years last birthday) 33 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean | | 17. SOCIAL SECURITY NO. 230-40-6082 | |
| 18. INFORMANT Mrs Irene Barrett, Springfield, Va. | | ADDRESS | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty alteration of liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, office bldg., etc.) vacant house | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 600 S. Dallas St. | | 22F. HOW DID INJURY OCCUR? housefire | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 22 71 ? | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/23/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/26/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Culpeper National Cemetery | | 24D. LOCATION (City, town, or county) (State) Culpeper, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert A. Felt | |
| 25C. FUNERAL DIRECTOR Demaine Funeral Home, Alexandria, Va. | | ADDRESS | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Constance Habey (Harvey)

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
Day

Year

Hour

3:45 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

3. DATE
PRONOUNCED DEADMonth
Day

Year

Hour

3:45 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Md.

B. COUNTY

6. SEX

female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

May 27 - 1936

10. AGE (In years
last birthday)

34+

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1627 E. Preston Street

11. BIRTH PLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Arthur Harvey

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic maid

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Regina Howell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

216-32-6819

18. INFORMANT

Regina Harvey

ADDRESS

Sond

19.

E 965 X 1

CAUSE OF DEATH

Gunshot wound of head

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes (head)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

House

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

XXXX 4506 Prospect Circle

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

1

23

71

2:30

p m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject was shot by boyfriend.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

1/25/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-30-71

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION (City, town, or county)

Balt

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1971

25B. NAME OF REGISTRAR

P. B. S. 2-3-71

25C. FUNERAL DIRECTOR

Crispin on Brantley

ADDRESS

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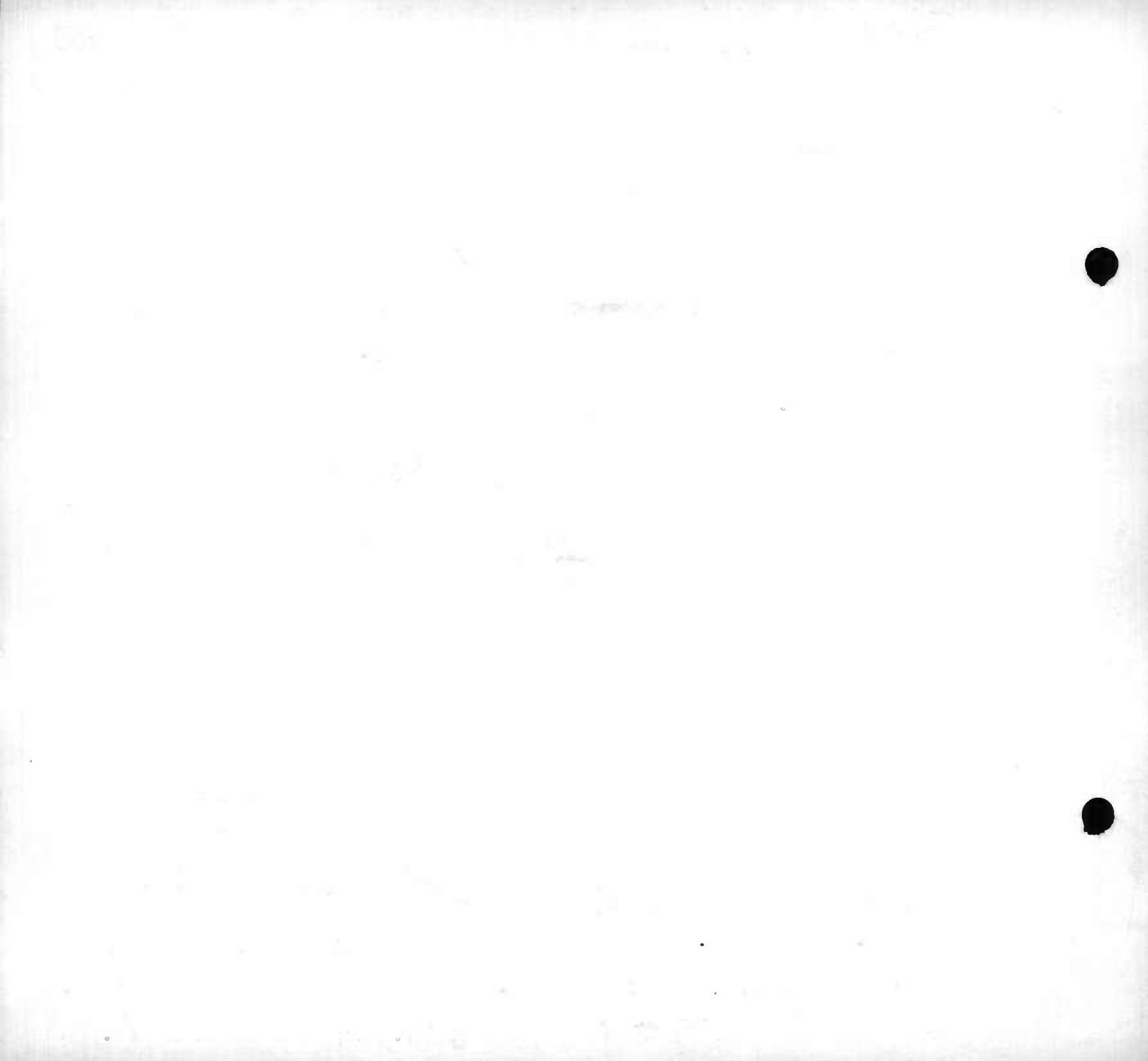
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0855</u> | |
|--|-------------------------|--|---|---|---|
| BIRTH NO. <u>T-460</u> | | 71 0855 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Taylor, Bernard H.</u> | | | 2. DATE AND HOUR OF DEATH <u>1/22/71</u> <u>7:10</u> P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital Complex</u> <u>2600 Liberty Heights Ave.</u> <u>Baltimore, Maryland 21215</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1511</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3700 Secquiora Ave.</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Black</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/22/92</u> | 9. AGE (In years lost birthday) <u>76</u> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u> |
| 13. FATHER'S NAME <u>Jesse Taylor</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary J. Tate</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u> | | 16. SOCIAL SECURITY NO. <u>217329397</u> | 17. INFORMANT ADDRESS <u>Mrs.. Berdine Alexander-Daughter Same</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>199.0 + 250.9</u> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Carcinoma</u> (B) <u>Diabetes Mellitus</u> (C) <u>Arterio sclerosis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/27/70</u> 19 to <u>1/22/71</u> 19 that (I) (we) last saw the deceased alive on <u>1/22/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Percival C. Smith</u> DEGREE | | | | 23B. DATE SIGNED <u>1/25/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. Percival C. Smith</u> DEGREE | | | | 23D. ADDRESS <u>2600 Liberty Heights Ave.. Baltimore, Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/27/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. park</u> | |
| 24D. LOCATION <u>Baltimore</u> | | 24E. (City, town, or county) | | 24F. (State) <u>MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Mary E. Lane</u> ADDRESS <u>802 Madison Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. Q-362 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0856 | |
| 1. NAME OF DECEASED (Type or Print) Joseph Quattrocche | | 2. DATE AND HOUR OF DEATH 1/26/71 10:10 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2608 | | C. CITY OR TOWN Baltimore | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 5-6-76 | | 9. AGE (In years last birthday) 94 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed | | 10B. KIND OF BUSINESS OR INDUSTRY Fruit & Produce | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Carmello Quattrocche | | 14. MOTHER'S MAIDEN NAME Fannie Mirabile | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-34-5409 | | 17. INFORMANT BCH Records | |
| 18. 600X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Anterior 2nd cardiac arrest 7 min. | | 19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic UTI's - dehydration (B) DUE TO, OR AS A CONSEQUENCE OF: BPH - Phimosis, Bal. Hydronephrosis (C) Chronic UTI's - dehydration | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/28/1970 to 1/26/1971 and that (we) lost saw the deceased alive on 1/26/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. L. Fleg M.D. | | 23B. DATE SIGNED 1/26/71 | | 23C. PHYSICIAN'S NAME (Type) J.L. Fleg, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/71 | | 24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | 24F. FUNERAL DIRECTOR George A. Weber | |
| 25A. DATE REC'D BY HEALTH DEPT. Jan 28 1971 | | 25B. NAME OF REGISTRAR 1 0 0 0 | | 25C. FUNERAL DIRECTOR ADDRESS 705 S. Ann St. #21231 | |

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| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
|---|--|--|--|--|--|--|--|---|--|
| LEROY GAINES | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | | Month Day Year Hour | | A. STATE B. COUNTY | |
| 38 University Hospital | | Balto. | | 1 26 1971 2 p | | Md. 1604 | | | |
| 6. SEX male | | 7. RACE negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. DATE OF BIRTH 5/18/1904 | | 10. AGE (In years last birthday) 66 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | 19. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| | | | | | | (A) IMMEDIATE CAUSE Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| | | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| | | | | | | Cirrhosis of liver | | | |
| | | | | | | Fatty metamorphosis of liver | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | 1-27-71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 1/30/71 | | Carver Memorial Cemetery | | Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JAN 28 1971 | | Philip E. Taylor | | Eric P. Carroll | | 1712 W. North Ave | | | |

Letter from M.E.'s office

3-24-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0858 | | 71 0858 | |
|---|---------------------|---|--|---|--|---|------------------------------|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) LENA HENSON | | | | 2. DATE AND HOUR OF DEATH JAN 24 1971 5:02 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MARYLAND | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MARYLAND | | B. COUNTY 1802 | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 252 N. ARLINGTON AVE | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 1/8/19 | 9. AGE (in years last birthday) 52 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOLDSWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY ? | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME LOUIS HENSON | | | | 14. MOTHER'S MAIDEN NAME CARRIE JACKSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS OLD HOSP CHART | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4-10-90 250.9 | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PROBABLE ACUTE MYOCARDIAL INFARCTION | | ? 2 hrs. | |
| | | | | (B) ARTERIO SCLEROTIC CARDIOVASCULAR DIS ? DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | DIABETES MELLITUS | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) - | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) 1/24/71 3:41 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/24/71 3:41 PM to 1/24/71 5:02 PM and that (I) (we) lost saw the deceased alive on 1/24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Meyer R. Heyman M.D. | | | | 23B. DATE SIGNED 1/24/71 | | 23C. PHYSICIAN'S NAME (Type) MEYER R. HEYMAN M.D. | |
| 23D. ADDRESS UNIV. HOSP. | | | | 23E. DEGREE DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/29/71 | | 24C. NAME OF CEMETERY OR CREMATORY W. Auburn Cem. | | 24D. LOCATION (City, town or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Williams Funeral Home 3197 Schroeder St | | 25D. ADDRESS | |

Handwritten text, possibly a signature or date, located in the upper right quadrant.

Handwritten text at the bottom of the page, appearing to be a list or index of items, possibly related to a collection or inventory.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> M-253 71 0859 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | <div style="display: flex; justify-content: space-between;"> REG. NO. 71 0859 </div> | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MCINTYRE, DAVID - H. | | 1/25/71 7:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of MD | | A. STATE MARYLAND B. COUNTY Q1216 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M 6. RACE N | | E. STREET AND NUMBER 1501 DUKELAND ST | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | F. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8/23/98 9. AGE (in years last birthday) 72 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME William H McIntyre | | 14. MOTHER'S MAIDEN NAME LAVRA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-18-8352 | |
| 17. INFORMANT LORRAINE WHITEHURST | | ADDRESS 2004 Kennebec Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CEREBRO VASCULAR ACCIDENT. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES | | RECURRENT CEREBRAL HAEMORRHAGE | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| II | | (C) _____ | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | OLD CVA - RESIDUAL Palsy - Decubitus ulcers - cystitis - SEPTICAEMIA | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| NO | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| <input type="checkbox"/> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| | | NO INJURY | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/23 19 71 to 1/25 19 71 that (I) (we) last saw the deceased alive on 1/25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE K. George Thomas | | 23B. DATE SIGNED 1/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) K. GEORGE THOMAS MD | | 23D. ADDRESS Lutheran Hospital of MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 1-28-71 | 24C. NAME of CEMETERY or CREMATORY CARVER MEM PR | 24D. LOCATION (City, town, or county) (State) LAURAL MD. |
| BURIAL | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | 25B. NAME OF REGISTRAR CLARE E. B. JR. | 25C. FUNERAL DIRECTOR W. C. MARCH | ADDRESS 928 E North Ave |

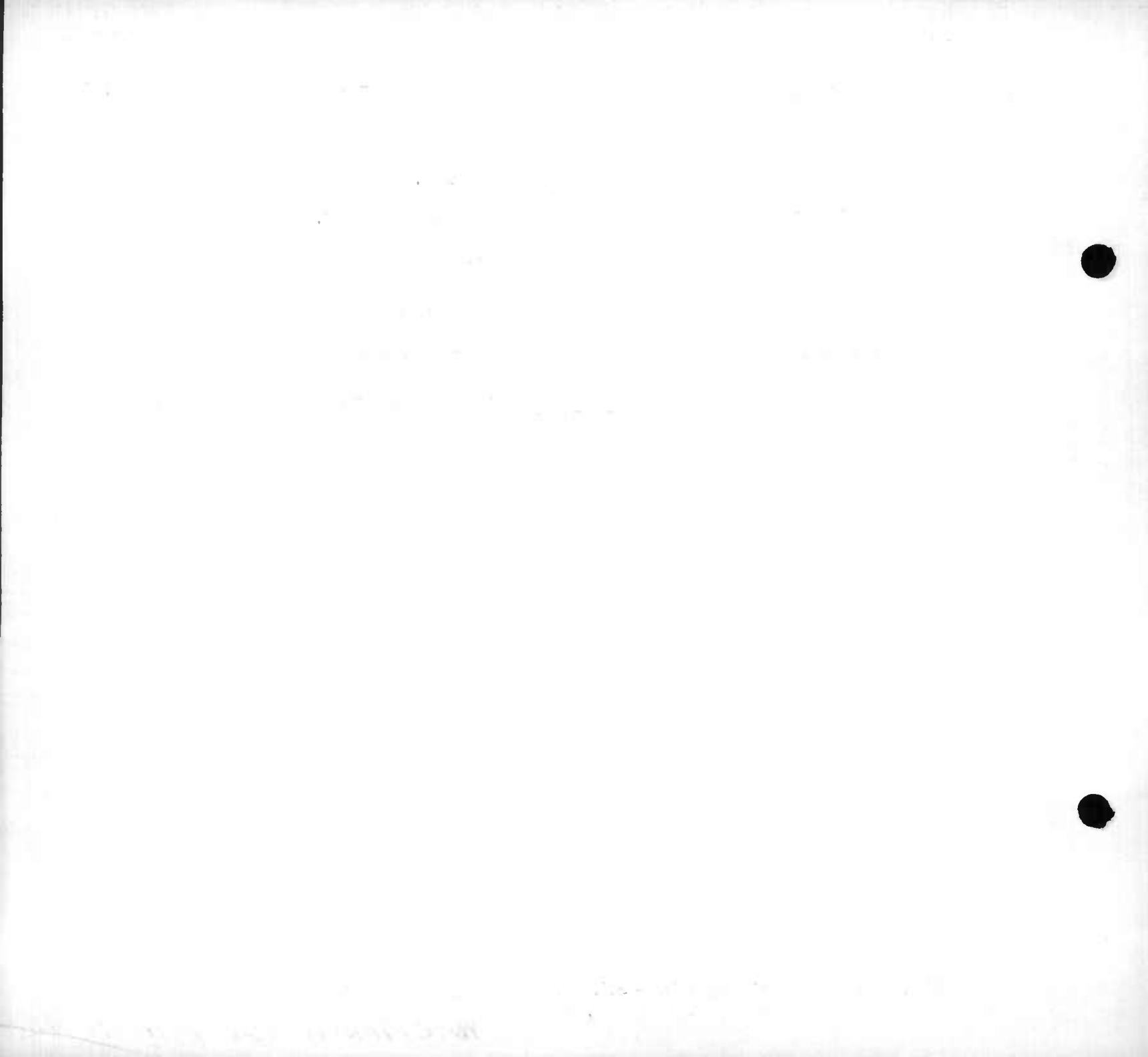
2004 Kennedy Ave

9/4/70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0860 |
|--|---|--|--|--|
| L-000 71 0860 | | BIRTH NO. | | |
| 1. NAME OF DECEASED (Type or Print) Harry Lee | | 2. DATE AND HOUR OF DEATH 1-26-71 8:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Center | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1513 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2620 Shirley Ave. | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-12-1888 | 9. AGE (In years last birthday) 82 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME UNKNOWN | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. 220-01-9670 | | 17. INFORMANT ADDRESS ELLA SMITH 2620 Shirley Ave | | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (B) DUE TO, OR AS A CONSEQUENCE OF: A-S. C. V. Disease (C) Chronic Lung Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 weeks ? ? |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 12/2 19 70 to 1/26 19 71 that (I) (we) last saw the deceased alive on 1/9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Joseph S. Blum | | 23B. DATE SIGNED 1/26/71 | | 23C. PHYSICIAN'S NAME (Type) |
| 23D. ADDRESS 1115 N. Calver St | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | |
| 24B. DATE 1-29-71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem | | 24D. LOCATION (City, town, or county) (State) Anne Arundel Co Md. |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Wm E. Barch | | 25C. FUNERAL DIRECTOR ADDRESS 928 E North Ave |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0861

F-630
BIRTH NO. 70-18419

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) SEAN (Shane) Ford | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2703 Boone St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 26 71 10:20 a M. | |
| 6. SEX male | | 7. RACE colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 904 | |
| 9. DATE OF BIRTH 10-14-70 | | 10. AGE (In years last birthday) 3 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME MARLO BELLAMY | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME DORIEE M. FORD | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS DORIEE FORD 2703 BOONE ST. | |
| 19. CAUSE OF DEATH 795K I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner <input type="checkbox"/> DATE SIGNED 1/26/71 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-29-70 | |
| 24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM PA | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR WMC MARCH 928 E NORTH | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |

1980

FEDERAL BUREAU OF INVESTIGATION

ACADEMY BOND

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0862 |
|---|--|---|--|---|
| B-530 71 0862 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Bennett, Amanda | | 2. DATE AND HOUR OF DEATH 1-24-71 10 p M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mt. Sinai Nursing Home 4613 Park Heights Ave. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2788 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5339 Cuthbert Ave. | | |
| 5. SEX F | 6. RACE Blk | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-7-1900 | 9. AGE (In years last birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) S.C. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME WARREN JOHNSON | | 14. MOTHER'S MAIDEN NAME CYNDA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BRLYN VIOLA JAMES 2058 UNION ST. NY |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C-V-A. Right Hemiparesis Arterio-sclerotic C-V Disease | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A.) | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 16 19 71 to Jan 24 19 71 , that (I) (we) last saw the deceased alive on Jan 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Louis T. Lavy M.D. | | | | 23B. DATE SIGNED Jan 25 1971 |
| 23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY M.D. | | 23D. ADDRESS 3502 W. Rogers Ave Balt Md | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-29-71 | | 24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor MD | | 25C. FUNERAL DIRECTOR 000 ADDRESS 419 G. MARCH 928 E North Ave | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0863 | |
| C-600 | | 71 0863 | |
| BIRTH NO. | | BIRTH NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>Gary, Mr. James H. Jr.</u> | | 2. DATE AND HOUR OF DEATH <u>January 26 '71</u> <u>11¹⁵ PM</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2714</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick</u> <u>700 West 40th St. Baltimore, Md.</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>4401 ROLAND AVE</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 19-1887</u> 9. AGE (in years last birthday) <u>84</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate PROPRIETOR - RETIRED</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland - USA</u> | |
| 13. FATHER'S NAME <u>E. Stanley Gary</u> | | 14. MOTHER'S MAIDEN NAME <u>Wary Regan Maggill</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WWI</u> | | 16. SOCIAL SECURITY NO. <u>212-03-8310A</u> | |
| 17. INFORMANT <u>W. Winter R.N.</u> | | ADDRESS <u>412-3</u> | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> | | <u>3 days</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Brain Syndrome</u> | | <u>2 yrs</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION <u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>No</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>12-1</u> 19 <u>70</u> to <u>1-26</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>1-25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>E. Hunter Wilson pmp</u> | | 23B. DATE SIGNED <u>1-27-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>E. Hunter Wilson, Jr.</u> | | 23D. ADDRESS <u>700 W. 40th Street</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>1/28/71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | 25B. NAME OF REGISTRAR <u>2628 E. E. Jenkins</u> | 25C. FUNERAL DIRECTOR ADDRESS <u>H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u> | |

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11-28-11

Handwritten text, possibly a date or note, appearing upside down.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

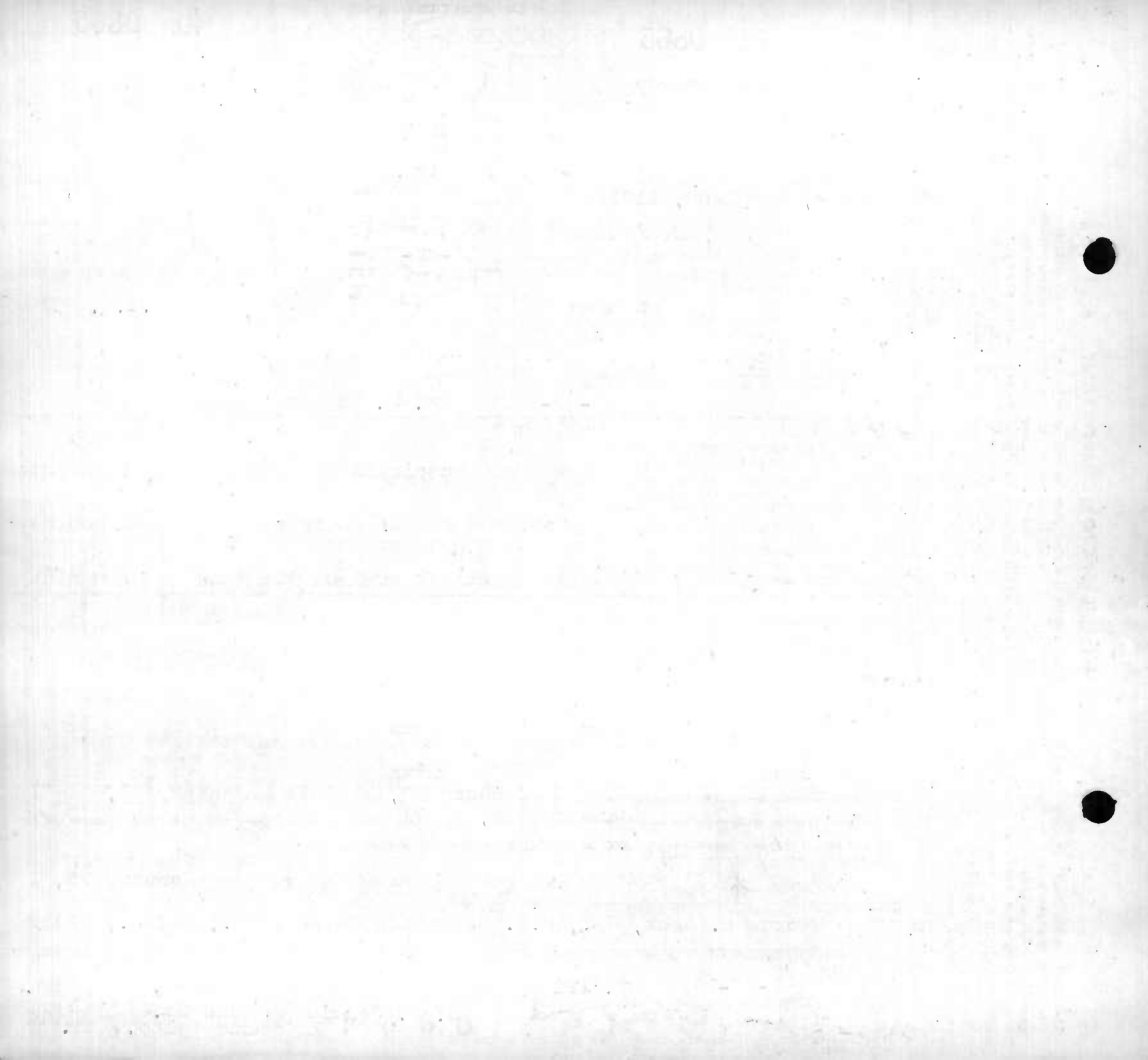
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|----------------------|---|---|--|---|--|---|--|--|
| 71 0864 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0864 | | | | |
| BIRTH NO. <u>C-510</u> | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>James P. Conniff</u> | | | | | 2. DATE AND HOUR OF DEATH <u>1/26/71</u> <u>4:30</u> A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>903</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> <u>Mercy Hospital</u> | | | | | C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | | E. STREET AND NUMBER <u>908 E. 37th St.</u> | | | | |
| 5. SEX <u>M.</u> | 6. RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/26/08</u> | 9. AGE (in years last birthday) <u>62</u> | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Hours | 13. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Boiler Local</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Patrick Conniff</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Theresa McEvoy</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Virginia Conniff</u> | | | | ADDRESS <u>908 E. 37th Street</u> |
| 18. <input checked="" type="checkbox"/> <u>CAUSE OF DEATH</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Pneumonia (st. lower lobe)</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>TB & Bronchogenic Ca</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>of the lung</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>1/26/71</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month <input type="checkbox"/> 1 Day <input type="checkbox"/> 1 Year <input type="checkbox"/> 1 Hour <input type="checkbox"/> | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> 19 <u>71</u> to <u>1/26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/26</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Pratima Bose MD</u> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>1/26/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>PRATIMA BOSE MD</u> | | | | | 23D. ADDRESS <u>Mercy Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>1-29-1971</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | | 25C. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons Co</u> | | | ADDRESS <u>21212 4903 York Road Balto., Md.</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0865 | |
|--|--|--|--|--|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Agnes Kennedy | | 2. DATE AND HOUR OF DEATH January 25, 1971 5:30 PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital Baltimore, Maryland, 21212 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2759 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1307 Southview Road | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-24-1908 | 9. AGE (In years last birthday) 62 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) New Jersey Atlantic Highlands, | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles Eustace | | | |
| 14. MOTHER'S MAIDEN NAME Dehlia Carey | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 216-48-3913 | | 17. INFORMANT Mr. J. Eugene Kennedy ADDRESS Same | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 3 months 3 months | |
| (A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: | | | | (B) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) Metastatic cancer of the lung DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED XXXX | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXXX | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) XXXX | |
| 21D. TIME OF INJURY (Approx.) XXXX | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? XXXX | |
| 22. I certify that (X) (this hospital) attended the deceased from January 12, 1971 to January 25, 1971, that (I) (XX) last saw the deceased alive on January 25, 1971 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (XX) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE George H. Sack, Jr. MD | | | | 23B. DATE SIGNED January 25, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D. | | | | 23D. ADDRESS 6200 Loch Raven Blvd., Balto., 21212 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-27-1971 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Erin Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Havre de Grace, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 8905 York Road Balto., Md. 21212 | | | |



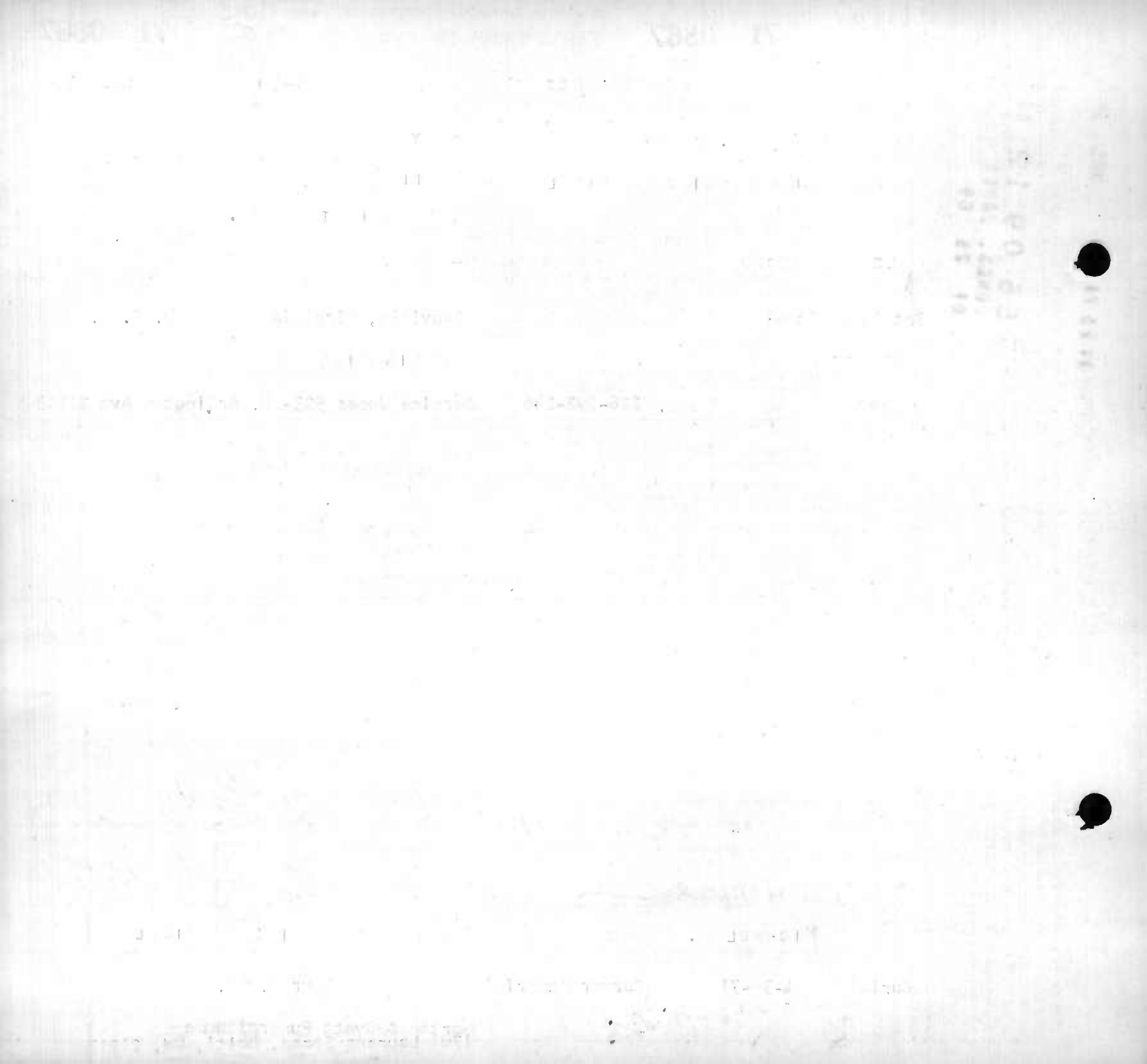
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0866 | |
|--|--------------------------------|---|---|--|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Burlew, Carolyn | | | | 2. DATE AND HOUR OF DEATH January 25, 1971 10:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital 5601 Loch Raven Boulevard Baltimore, Maryland 21212 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 21213 5. CITY OR TOWN Baltimore 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 2622 E. Biddle St. | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/08/81 | 9. AGE (In years lost birthday) 89 | 10. CITIZEN OF WHAT COUNTRY? U S A |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER | | | 11. BIRTHPLACE (State or foreign country) BROOKLYN N. Y. | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME JOHN BURLEW | | | 14. MOTHER'S MAIDEN NAME CHENNEF | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) () | | | 16. SOCIAL SECURITY NO. 220543044 | 17. INFORMANT ROBERT ALEXANDER ADDRESS 1214 PRIM ROSE A V 21237 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Multiple injuries from fall II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20. AUTOPSY? (Yes or No) XXX | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED XXX | | 20A. AUTOPSY? (Yes or No) XXX | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXX | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) XXX | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) XXX | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? XXX | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 11 19 70 to January 25 19 71 , that (I) (we) last saw the deceased alive on January 25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED January 25, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D. | | | | 23D. ADDRESS 6200 Loch Raven Blvd. Balto., 21212 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-28-71 | | 24C. NAME OF CEMETERY or CREMATORY MT OLIVET CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTO MD | | 24E. FUNERAL DIRECTOR FREDERICK J. COOK | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. ADDRESS FREDERICK J. COOK | |

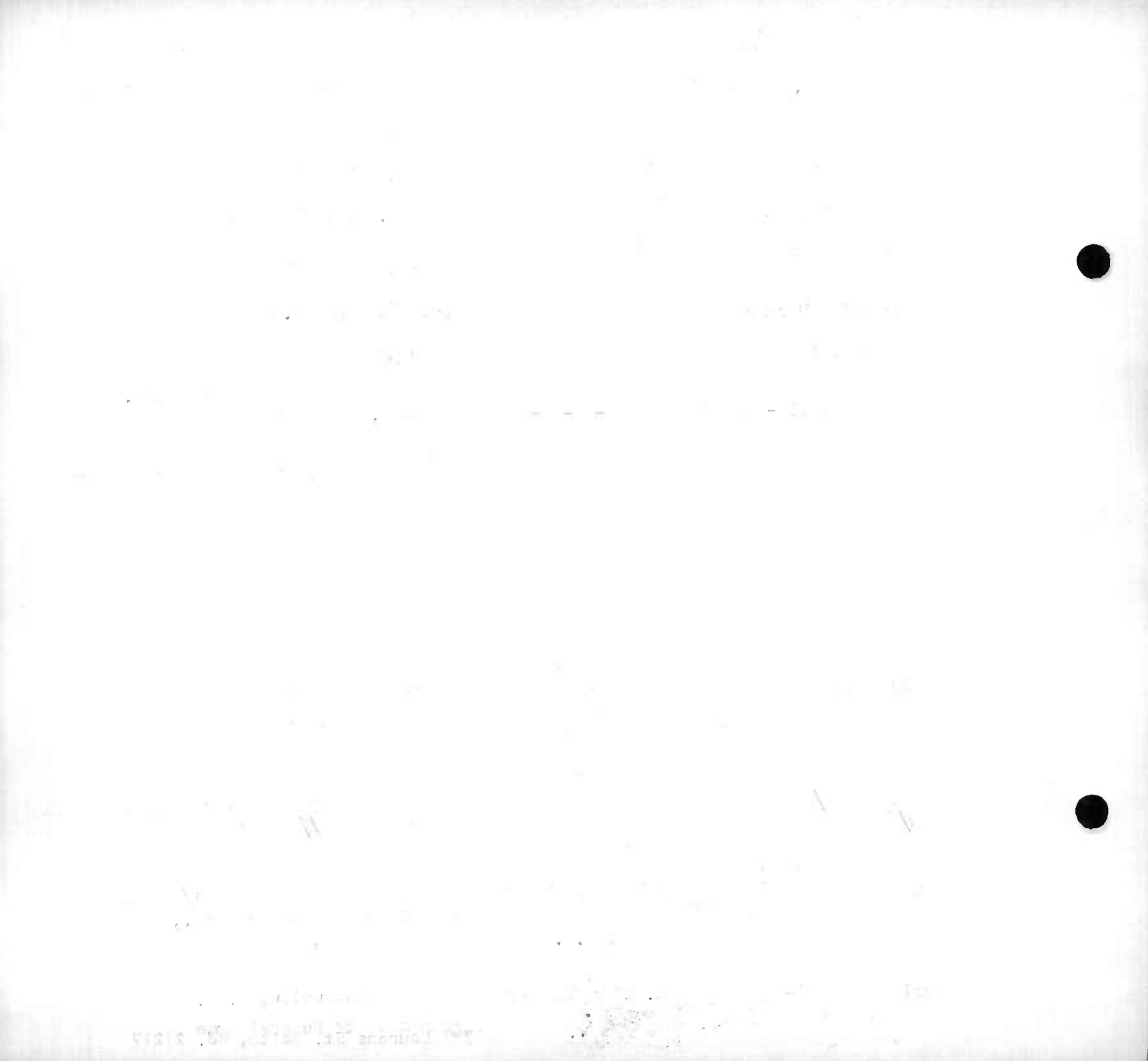
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0867 | |
|--|---------------|--|--|--|---|
| BIRTH NO. 520 | | 71 0867 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) JAMES R. JONES | | | 2. DATE AND HOUR OF DEATH 01-25-71 3:20 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL | | | A. STATE MARYLAND | | |
| CITY OR TOWN BALTIMORE | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 523 ARLINGTON AVE. | | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-25-09 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Danville, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME GEORGE JONES | | 14. MOTHER'S MAIDEN NAME JULIA MILLER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 226-092-246 | | 17. INFORMANT ADDRESS Bernice Jones 523- N. Arlington Ave 21223 | |
| 18. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Valve Disease | | |
| ANTECEDENT CAUSES | | | (C) Calcification | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25 19 71 to 1/25 19 71, that (I) (we) last saw the deceased alive on 1/25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael H. Mason | | | | 23B. DATE SIGNED 1/27/71 | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL H. MASON | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-30-71 | | 24C. NAME OF CEMETERY or CREMATORY Carver Memorial | |
| 24D. LOCATION (City, town, or county) (State) Laurel, Md. | | 24E. FUNERAL DIRECTOR | | 24F. ADDRESS | |
| 25A. DATE RECEIVED BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Morton & Dyett Funeral Home | |
| 25D. ADDRESS 1701 Laurens Street, Balti, Md. 21217 | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0868</u> | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. <u>B-400</u> | | 71 0868 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>BELL, JAMES HARDY</u> | | | 2. DATE AND HOUR OF DEATH <u>1/24/71</u> <u>11:45 P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Md 21218</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>1601</u> | | |
| | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>707 N. Carrollton Ave</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/20/31</u> | 9. AGE (in years last birthday) <u>39</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u> | | | 11. BIRTHPLACE (State or foreign country) <u>PERU Orvn N.C</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Hardy Bell</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ethel Washington</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>2/5/53 - 1/28/55</u> | | | 16. SOCIAL SECURITY NO. <u>247-48-06-44</u> | | 17. INFORMANT ADDRESS <u>VA Hospital 3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u> |
| 18. CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Pancreatitis</u> | | | | | <u>3 weeks</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>1/22/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pancreatic abscess</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January 6th 19 71</u> to <u>January 24th 19 71</u> that (I) (we) last saw the deceased alive on <u>January 24th 19 71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>William Easton Walker, M.D.</u> | | | | 23B. DATE SIGNED <u>1/25/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>WILLIAM EASTON WALKER, M.D.</u> | | | | 23D. ADDRESS <u>3900 Loch Raven Blvd.,</u> <u>Baltimore, Maryland 21218</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-29-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Zion Cemetery</u> | |
| 24D. LOCATION <u>Lakewview, S. C.</u> | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Morton & Dye Funeral Home</u> <u>1701 Laurens St., Balto, Md. 21217</u> | |



FUNERAL DIRECTOR: IMPORTANT

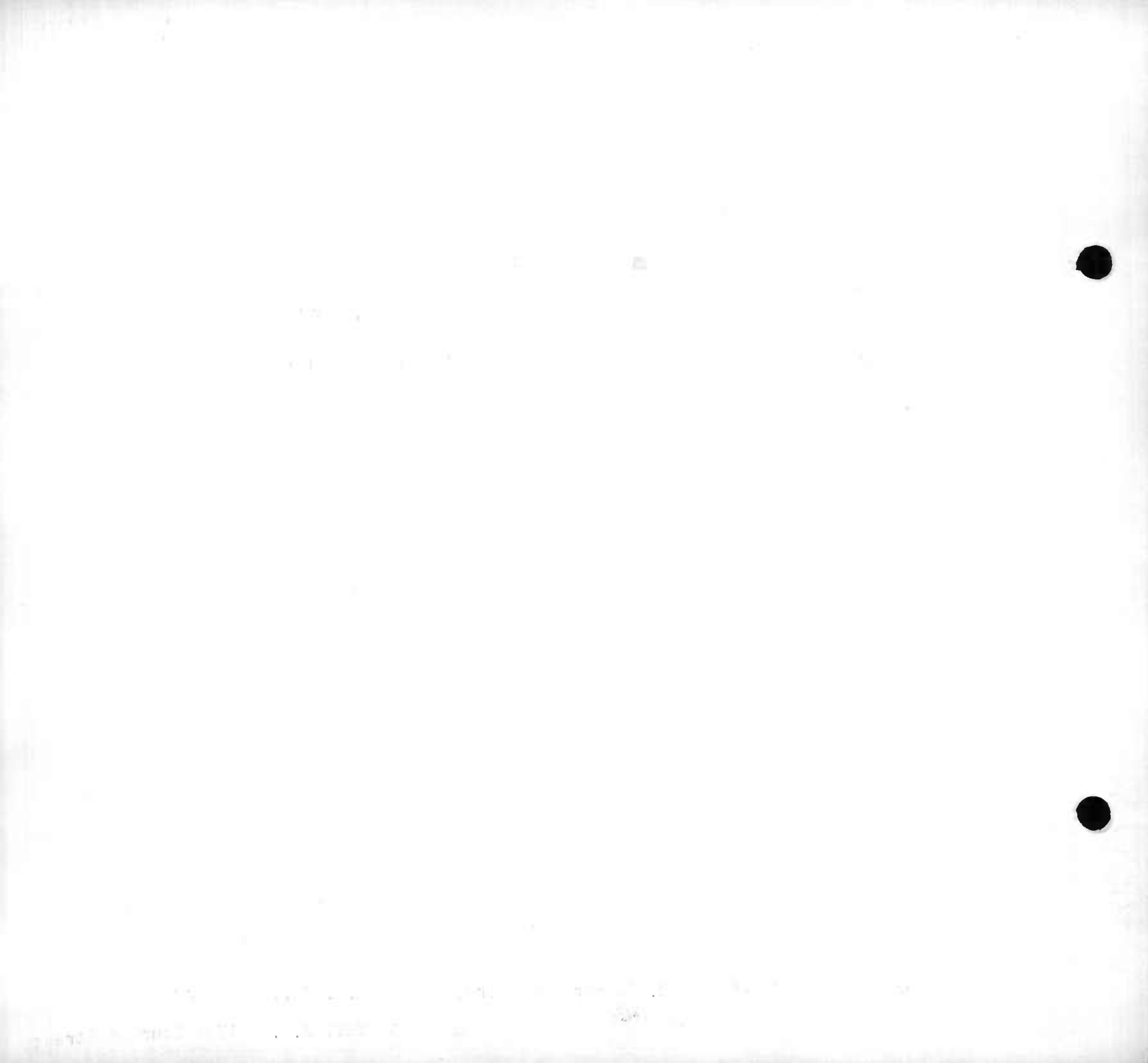
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-650 71 0869 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0869 | |
|---|-------------------------|---|------------------------------------|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JACK BROWN | | | | 2. DATE AND HOUR OF DEATH 1/26/71 12 45 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 The Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1604 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1829 Arunah Avenue | | | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/20/07 | 9. AGE (In years lost birthday) 64 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? U-S-A | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Mary Francis | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 263-01-3834 | | 17. INFORMANT Billie Brown ADDRESS Baltimore 21217 | | | |
| 18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Renal Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. CARDIOGENIC Shock Diabetes Mellitus | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal Failure (B) DUE TO, OR AS A CONSEQUENCE OF: CARDIOGENIC Shock (C) Diabetes Mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week 10 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/4 1971 to 1/26 1971 , that (I) (we) last saw the deceased alive on 1/26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert A. Vigersky, M.D. DEGREE | | | | 23B. DATE SIGNED 1/26/71 | | 23C. PHYSICIAN'S NAME (Type) Robert A. Vigersky, M.D. DEGREE | |
| | | | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-30-71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park Balto Md | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE RECEIVED BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR John E. [illegible] | | 25C. FUNERAL DIRECTOR Montgomery & Co. 21217 | | ADDRESS 1701- [illegible] St. Balto, Md | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

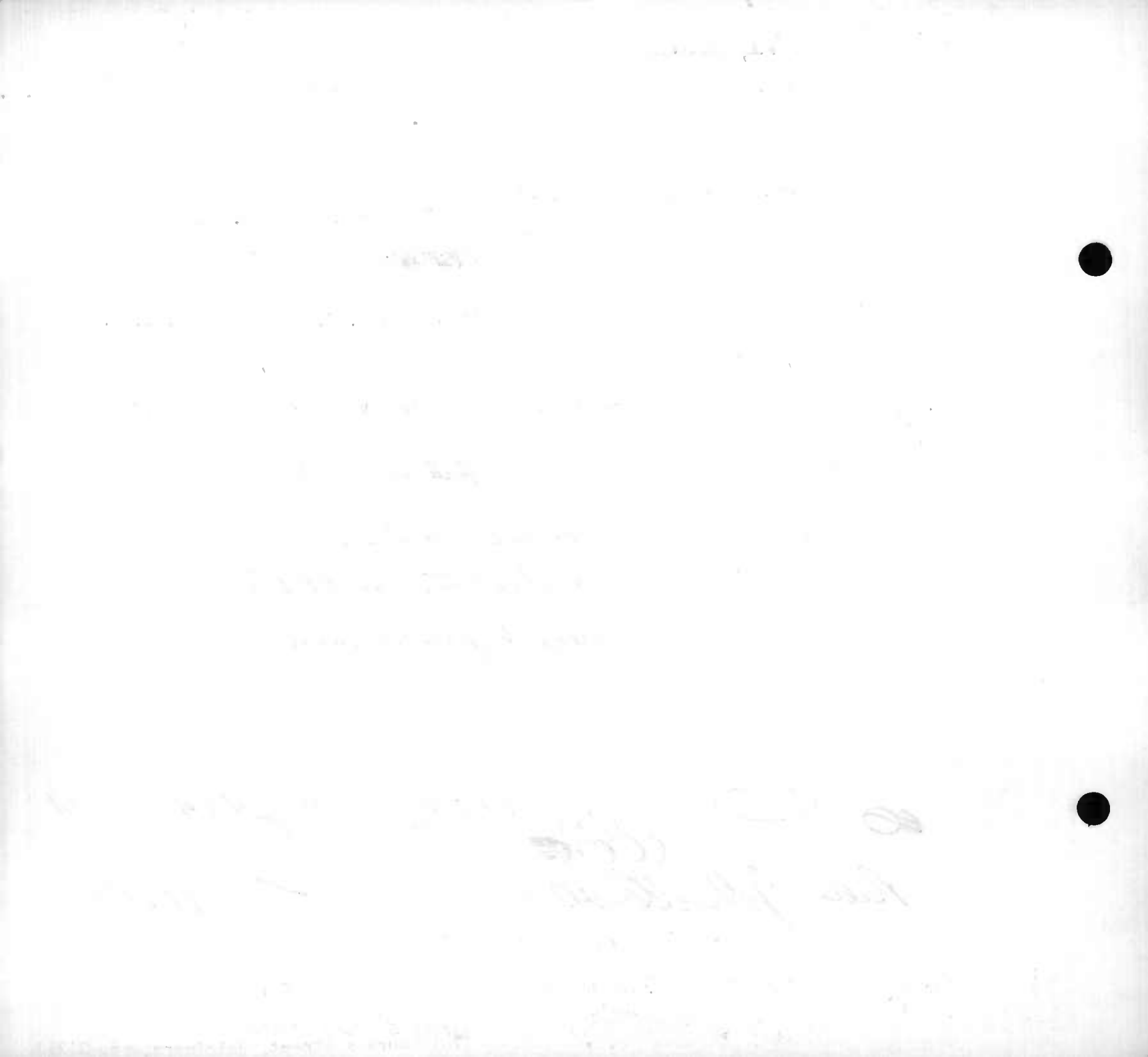
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0870 | |
|--|------------------|--|---|--|---|
| C-512 | | 71 0870 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Combs, Lucinda | | 1/22/71 12:35 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215 | | | A. STATE Maryland | | |
| | | | B. COUNTY ADCO 5200 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER Box 250 Donaldson Ave. | | |
| 5. SEX Female | 6. RACE Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 2/10/00 | 9. AGE (In years last birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME George Combs | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Arthenia Nick-Daughter |
| | | | | | ADDRESS Same 969-9043 |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 153-8 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Anemia | | | | | |
| (A) IMMEDIATE CAUSE Belvic Carcinoma DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma of Colon (resected) 65 DUE TO, OR AS A CONSEQUENCE OF: (C) Cong. Heart Fail. | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/22/71 19 to 1/25/71 19 that (I) (we) last saw the deceased alive on 1/25/71 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Webster Sewell M.D. | | | | 23B. DATE SIGNED Jan. 25, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) WEBSTER SEWELL M.D. | | | | 23D. ADDRESS 2600 Liberty Heights Ave. Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-28-71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. Feltz, Jr. | | 25C. FUNERAL DIRECTOR MORTON & DRETT F.H. | |
| | | | | ADDRESS 1701 Laurens Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-----------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71 0871</u> | |
| S-363 <u>71 0871</u> | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Stroud, Joshua (Josuay)</u> | | 2. DATE AND HOUR OF DEATH <u>1/24/71</u> <u>1:25</u> <u>p.m.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>45 Good Samaritan Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>909</u> | |
| | | C. CITY OR TOWN <u>Baltimore</u> | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER <u>1520 Holbrook St. 21202</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>B</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>09/5/01</u> |
| | | 9. AGE (In years last birthday) <u>69</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>York Cty. S. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Stroud, John</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>212-563384</u> | 17. INFORMANT <u>Fletcher Powell</u> ADDRESS <u>1520 Holbrook Street 21202</u> |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>recent pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>70</u> to <u>1/24</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>1/24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Richard J. Owellen</u> | | 23B. DATE SIGNED <u>1/24/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Richard J. Owellen, M.D.</u> | | 23D. ADDRESS <u>The Johns Hopkins Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>1-28-71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE RECD BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | |
| 25C. FUNERAL DIRECTOR <u>Morton & Dyett Funeral Home</u> | | ADDRESS <u>1701 Laurens Street, Baltimore, Md. 21217</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

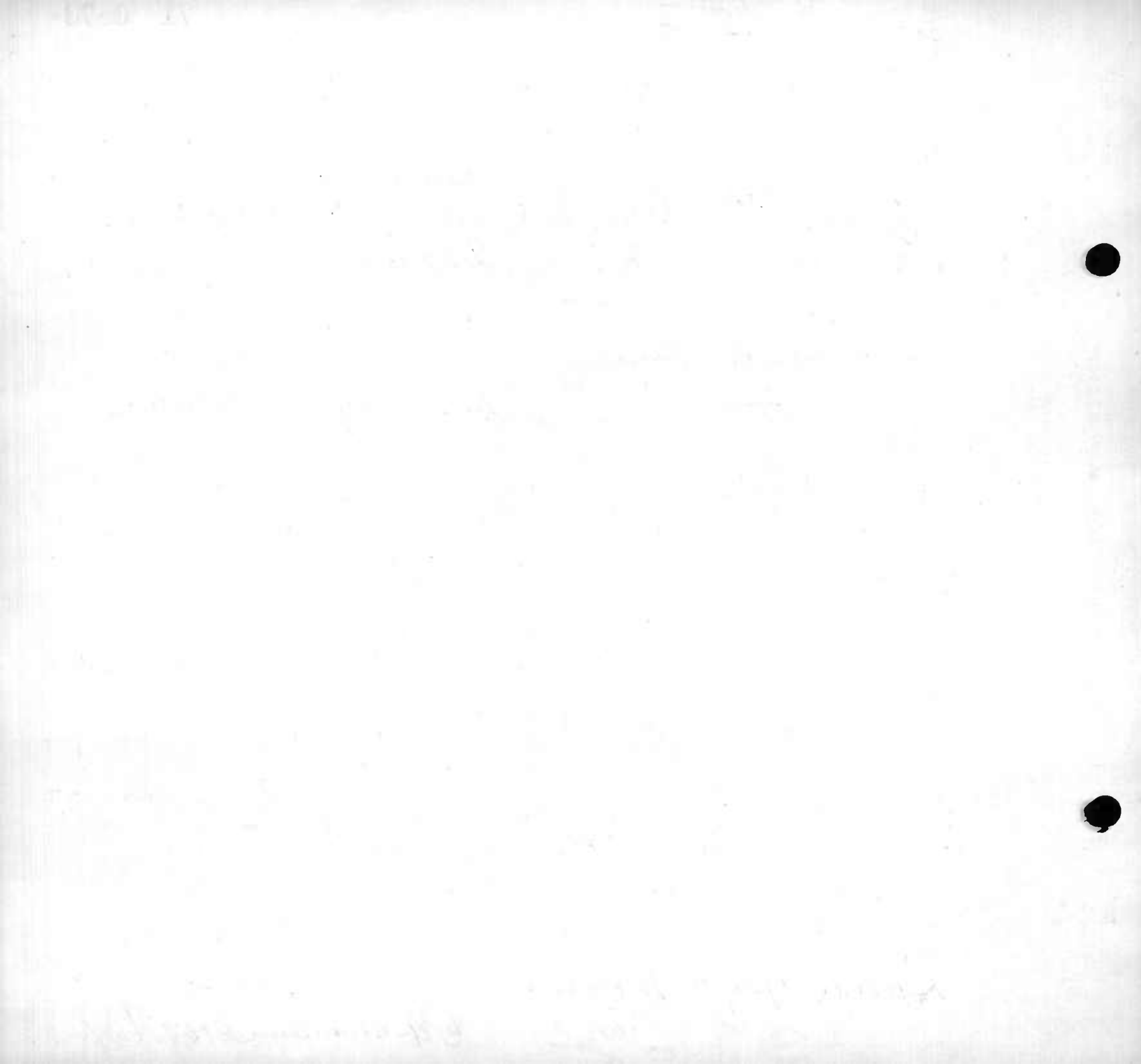
| C-636 71 0872 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0872 | |
|--|------------------|---|-----------------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) CROWDER MATTIE | | 2. DATE AND HOUR OF DEATH 1/27/71 6:15 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of MD IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 21216 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2102-N-SMALLWOOD ST. | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-14-11? | | 9. AGE (In years last birthday) 59? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Lee Pearson | | | |
| 14. MOTHER'S MAIDEN NAME Louella Smith | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Amos A. Bell ADDRESS 2102 Smallwood St Bt 16 Mf | | | |
| 18. 431.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH CEREBRO - VASCULAR ACCIDENT (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL HAEMORRHAGE (B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION (C) HYPERTENSIVE ENCEPHALOPATHY (SUSPECT) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? NO | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE K George Thomas MD | | | | 23B. DATE SIGNED 1/27/71 | |
| 23C. PHYSICIAN'S NAME (Type) K GEORGE THOMAS MD | | 23D. ADDRESS Lutheran Hospital of MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/31/71 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial | |
| 24D. LOCATION (City, town, or county) Baltimore Md | | 24E. STATE Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Charles E. Fisher | | 25C. FUNERAL DIRECTOR Amos A. Bell ADDRESS 2102 Smallwood St Bt 16 Mf | |

For 11/16/1902
L. J. Sullivan
L. J. Sullivan
L. J. Sullivan

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

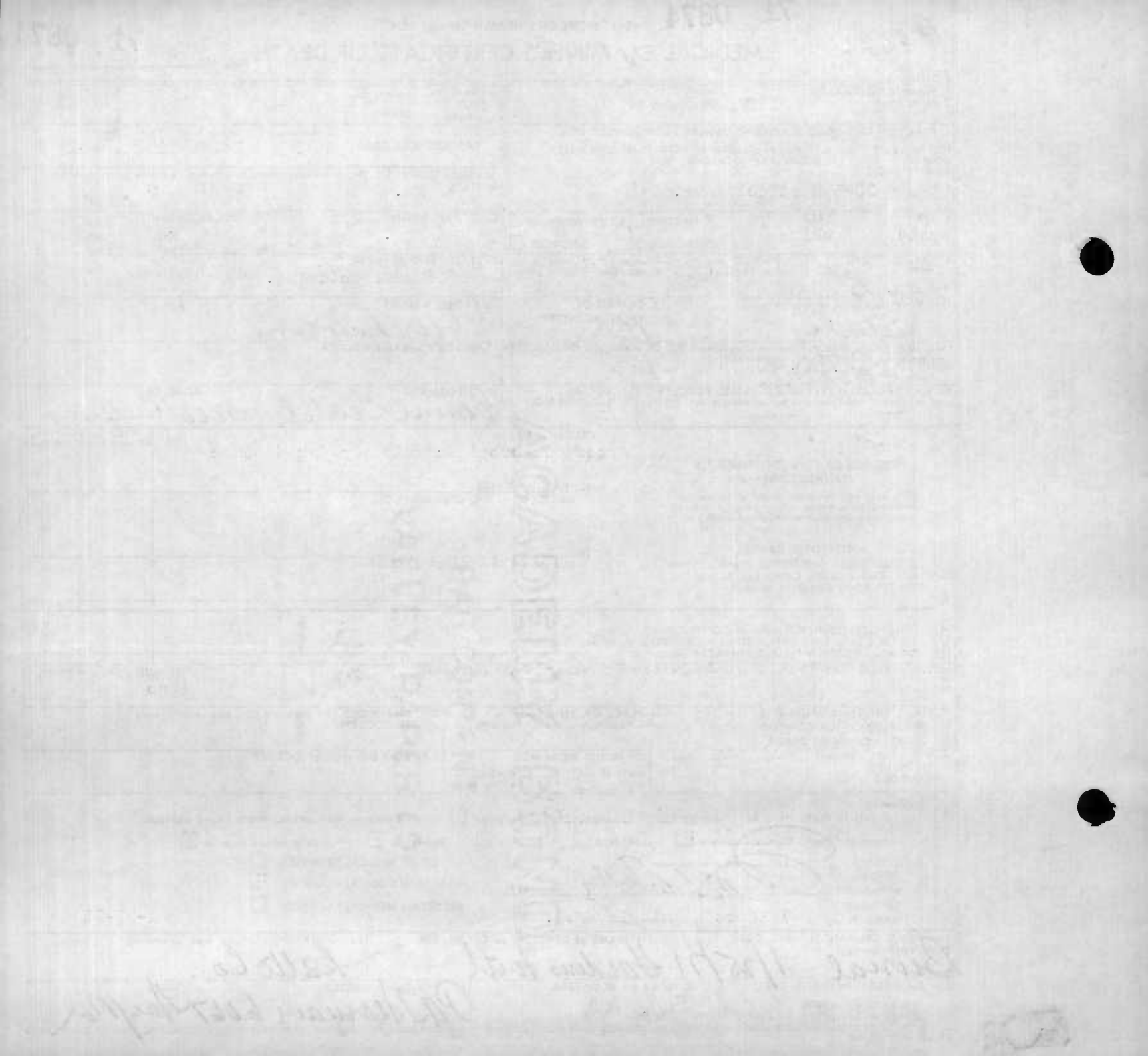
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|--|--|--|---|--|
| S-340 | | 71 0873 | | 71 0873 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Hessler A Stahl | | Jan 22, 1971 10 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| 00 2708 Hemlock Ave | | Md | | 2706 | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 7 | | W | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| | | | | Feb 1, 1888 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Grandville Myers | | Unknown | | 82 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give way or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Mrs Ruby Lane | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 412.3 I | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 3 mos | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | Coronary artery dis | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 48 to Jan 22 19 71, that (I) (we) last saw the deceased alive on Jan 20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Donald Jandorf | | 1-25-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| R Donald Jandorf | | 7403 Hartford Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 1/25/71 | | Moreland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 28 1971 | | Charles E. ... | | J. H. ... | |
| 25D. LOCATION (City, town, or county) | | 25E. ADDRESS | | | |
| Baltimore Co | | 6067 Hartford Rd | | | |



M-620 71 0874 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 0874

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) PIETRO MARASA | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3006 Westfield Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 21 1971 4:45 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH JAN 15 | | 10. AGE (In years last birthday) 80 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 14B. KIND OF BUSINESS OR INDUSTRY City. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Connie Gentile | | ADDRESS 3006 Westfield Ave | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-22-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Gardens South | | 24D. LOCATION (City, town, or county) (State) Balto Co | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR W. J. Deegan | | ADDRESS 6067 Taylor | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0875

BIRTH NO.

| | | | |
|---|---------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Ulysses Elyse Huggins, Jr.</u> | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> | | 3. DATE PRONOUNCED DEAD Month Day Year Hour <u>1 25 71 9:05 p</u> M. | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>807</u> | |
| 6. SEX <u>male</u> | 7. RACE <u>colored</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH <u>1-3-1949</u> | | 10. AGE (In years lost birthday) <u>21</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 17. SOCIAL SECURITY NO. | |
| 13. FATHER'S NAME <u>MATHEW Huggins</u> | | 15. MOTHER'S MAIDEN NAME <u>ANNIE MAE LAWRENCE</u> | |
| 18. INFORMANT <u>MATHEW Huggins</u> | | ADDRESS | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>E965X</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (A) IMMEDIATE CAUSE Multiple gunshot wounds DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ | |
| 20A. DATE OF OPERATION <u>21</u> | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>XXXX sidewalk</u> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>2200 Blk. Harford Rd.</u> | | 22F. HOW DID INJURY OCCUR? <u>shot during altercation</u> | |
| 22D. TIME OF INJURY (APPROX.) <u>1 25 71 8:40p</u> | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/26/71</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-30-71</u> | |
| 24C. NAME OF CEMETERY or CREMATORY <u>MT. AUBURN CEM</u> | | 24D. LOCATION (City, town, or county) (State) <u>Westport, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>Charles E. Huggins</u> | |
| 25C. FUNERAL DIRECTOR <u>Spitzer & Elickson</u> | | ADDRESS | |

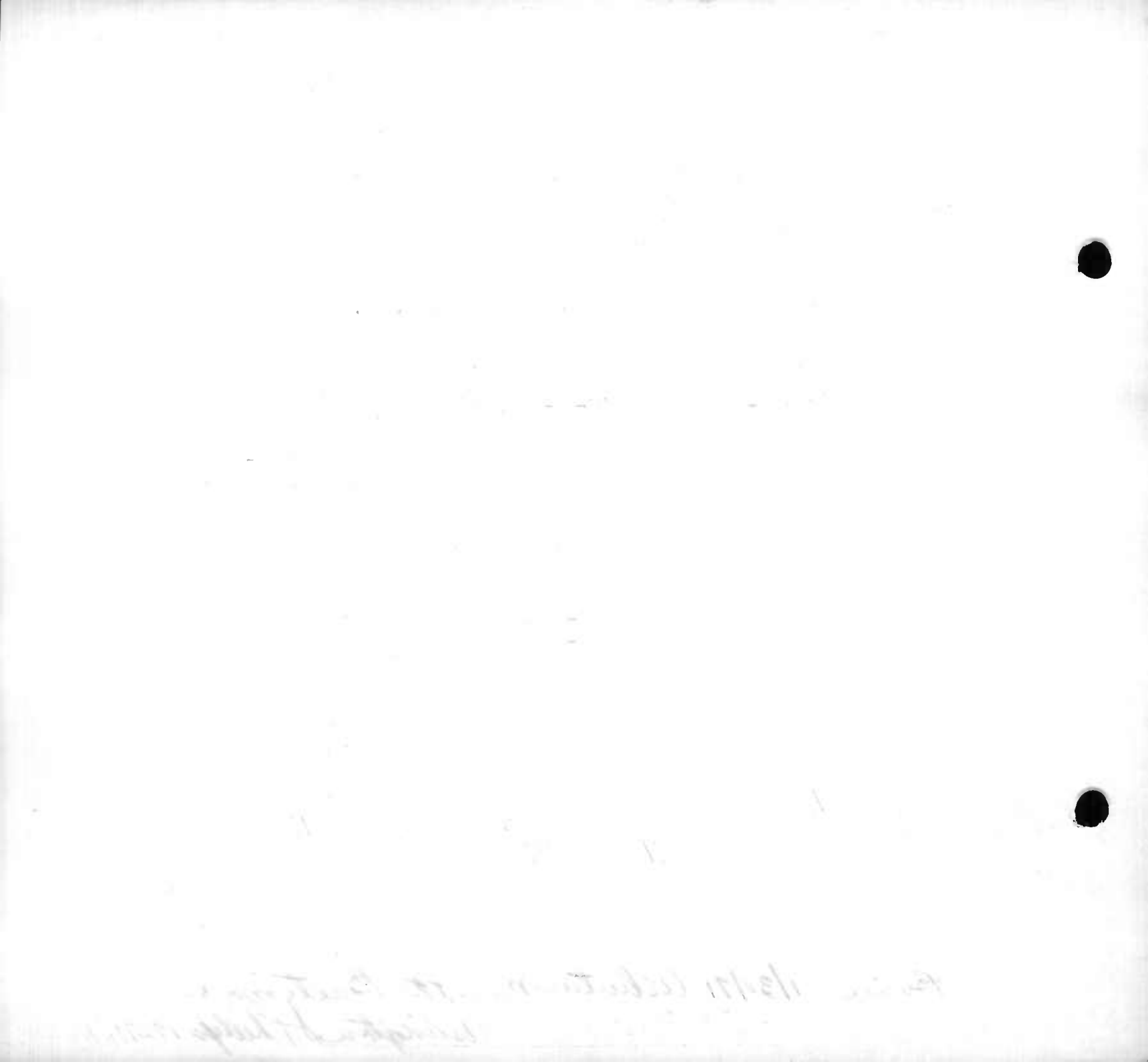
1932

RECEIVED BY BODEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-525 | | 71 0876 | | BALTIMORE CITY HEALTH DEPARTMENT | |
|---|--|--|---|--|---|
| CERTIFICATE OF DEATH | | | | REG. NO. 71 0876 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | TENSON, NATHANIEL | | 1/25/71 12:55 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | Maryland | | |
| 5. SEX | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| Male | | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH |
| Truck driver | | | Imperial paper Co | | 7/4/33 |
| 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | 9. AGE (In years last birthday) |
| Elkham W. Va. | | | USA | | 37 |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Joseph Tenson | | | Gertrude Boone | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| Yes 1/22/53 - 12/28/54 | | | 233-48-9971 | | VA Hospital Records Baltimore, Maryland 21218 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | Hepatic failure with cirrhosis of liver-early with marked fatty changes | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Chronic alcoholism | | many years |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | 1- Pulmonary tuberculosis probably active | | |
| | | | 2- Hydrothorax bilateral | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPST? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (If this hospital) attended the deceased from December 8th 1971 to January 25th 1971 that (If we) lost saw the deceased alive on January 25th 1971 and that in (My) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| [Signature] | | | | 1/26/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| SAYED T. A. SHAN | | | | 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/30/71 | | Arbutus mem. pk | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JAN 28 1971 | | [Signature] | | [Signature] | |
| | | | | ADDRESS | |
| | | | | 1727 N. Mount... | |



C-455

71 0877

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0877

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) WALLACE CALAMAN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 21 1971 7 a M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1/19/37 | | 10. AGE (In years last birthday) 34 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Leonard Calaman | | E. STREET AND NUMBER 1213 Madison Ave. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 14B. KIND OF BUSINESS OR INDUSTRY Herbert C. Roberts Co | |
| 15. MOTHER'S MAIDEN NAME Grace Curry | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 217-38-0468 | | 18. INFORMANT Henrietta Calaman 1213 Madison Avenue | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary thrombo-emboli ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 40% body burns OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Dump | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rob. Tyler Dump | | 53-00 | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1-19-71 3:10 P.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? Fire & explosion from aerosol cans | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 1-22-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/25/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert C. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Arlington S. Phillips | | ADDRESS 1727 North Monroe St | |

ACADEMY FOUNC

1966 CONFED

VALLEY STATE CO

1968 A

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0878 | | REG. NO. 71 0878 | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. <u>B-650</u> | | 71 0878 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Viola Broom</u> | | | | 2. DATE AND HOUR OF DEATH <u>Jan. 25, 1971</u> <u>6:25 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>HILTON NURSING Home</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1504</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>FEMALE</u> | | 6. RACE <u>NEGRO</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/5/27</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) <u>43</u> | | 11. BIRTHPLACE (State or foreign country) <u>Chesterfield S. C.</u> | |
| 13. FATHER'S NAME <u>Sidney Bowman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Connie Marshall - 2738 Riggs Ave Balt. Md</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-20-3491</u> | | 17. INFORMANT <u>Clarence Brown 1610 N. Ave. Balt. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>412.4 + I 250.9</u> CAUSE OF DEATH <u>A.S.C.U.D.</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes mellitus</u> | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>1-20-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-20-1970</u> to <u>1-25-1971</u> that (I) (we) last saw the deceased alive on <u>1-5-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Barbu Calin</u> | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>1-26-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>BARBU CALIN</u> | | | | 23D. ADDRESS <u>831 Poplar Grove</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/30/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Ch.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Baker, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>Volunteer Phillips</u> | | ADDRESS <u>1727 N. Meade St.</u> | |

1848-25712

1/2-1/11 (Robert Thomas A. Burtin)
1/2-1/11 (Robert Thomas A. Burtin)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 0879 | | 71 0879 | |
| BIRTH NO. | | S-530 | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>Smith, Rayford</u> | | | 2. DATE AND HOUR OF DEATH <u>Jan 22, 1971</u> <u>12:55 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>212171504</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles General Hospital</u> | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER <u>2002 N. PAYSON STREET</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/28/07</u> | 9. AGE (In years) <u>63</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 11. BIRTHPLACE (State or foreign country) <u>S. CAR.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Jiles Smith</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sallie M.N. Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>217-03-5306</u> | | 17. INFORMANT <u>Harvey Smith</u> ADDRESS <u>1717 N. MONROE ST.</u> |
| 18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH <u>Cerebrovascular Accident (Stroke)</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> 19 <u>71</u> to <u>JAN. 22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>JAN. 22</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. H. Haden</u> | | | 23B. DATE SIGNED <u>1-22-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>R. Loy</u> |
| 23D. ADDRESS | | | 23E. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/26/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Ashburton Mem. Ch. B. Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u> | |
| 25C. FUNERAL DIRECTOR <u>Orville S. Phillips</u> | | 25D. ADDRESS <u>1727 N. MONROE ST.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0880 | |
|---|--------------------------------|--|--|---|--|
| S-362 71 0880 BIRTH NO. 1. NAME OF DECEASED (Type or Print) CHARLES E. STRICKLAND | | CERTIFICATE OF DEATH | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33 | | 2. DATE AND HOUR OF DEATH 1/24/71 3:30PM M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2749 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1627 HEATHFIELD RD. | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/20/25 | | 9. AGE (In years last birth) 45 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Durham, N.C. | |
| 13. FATHER'S NAME RUFUS STRICKLAND | | 14. MOTHER'S MAIDEN NAME CLEO JONES | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219 10 4505 | | 17. INFORMANT A. Ruth Strickland | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTATIC CARCINOMA, LUNG DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 3/16/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PAIN | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/16 19 71 to 1/24 19 71 , that (I) (we) last saw the deceased alive on 1/24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edward R. Laws Jr. M.D. | | | | 23B. DATE SIGNED 1/24/71 | |
| 23C. PHYSICIAN'S NAME (Type) EDWARD R. LAWS, JR., M.D. | | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial | |
| 24D. LOCATION (City, town, or county) (Sign) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR William J. Sullivan | | | |

Machinist

Truckee, T.C.

A. J. Smith

Received 1/3/11
Machinist

B-630

71 0881

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 0881

REG. NO.

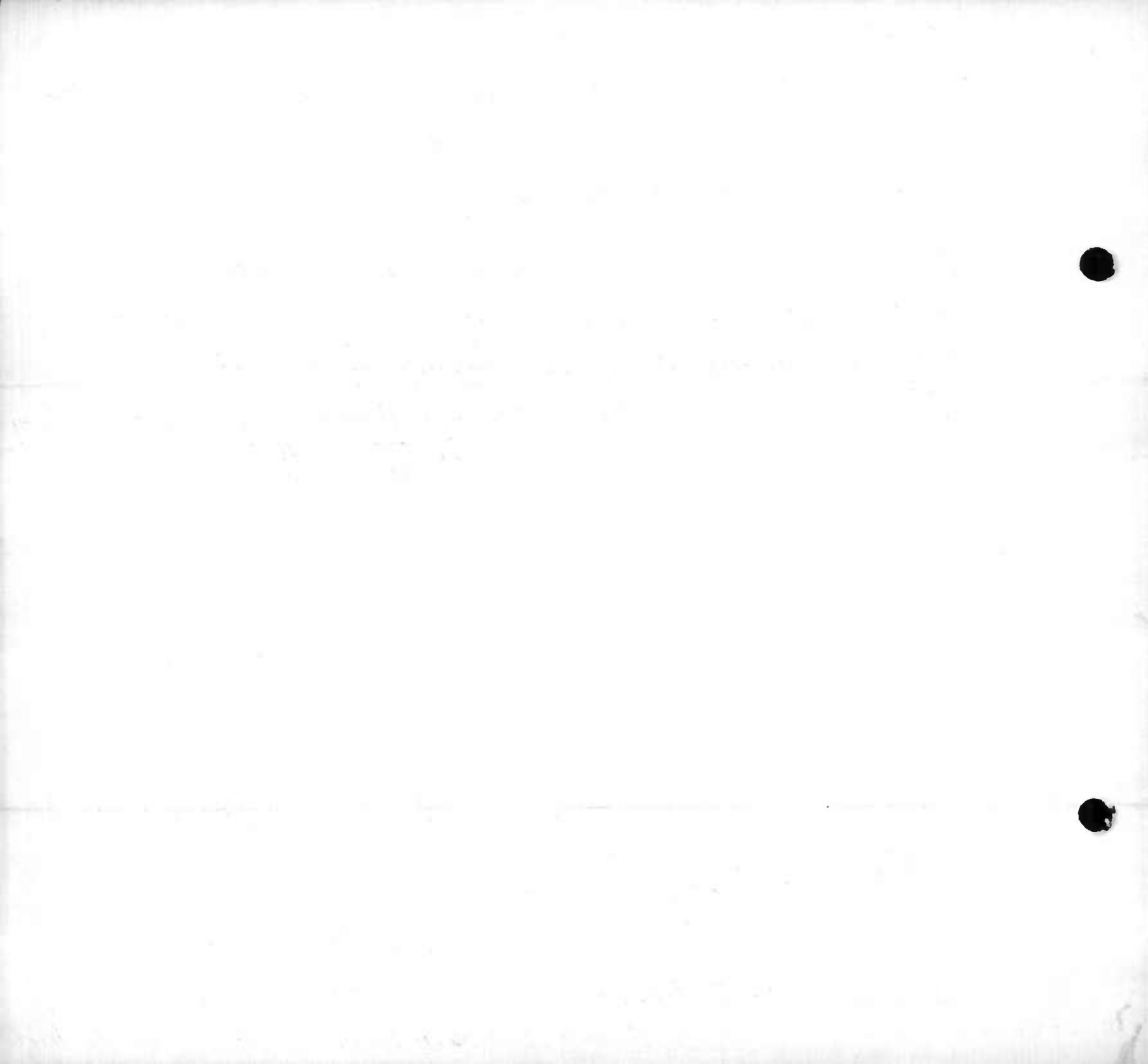
BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Geraldine Beard | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 25 Year 71 Hour 6:10 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD Month 1 Day 25 Year 71 Hour 6:10 a. M. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH Oct 27 1928 | | 10. AGE (in years last birthday) 42 | |
| 11. BIRTHPLACE (State or foreign country) Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor | | 14B. KIND OF BUSINESS OR INDUSTRY Credit Card Co | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 21922 9394 | |
| 18. INFORMANT Linda Zopp | | ADDRESS Same | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) yes | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Peter Lipkovic M.D. | | DATE SIGNED 1/25/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-28-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem | | 24D. LOCATION (City, town, or county) (State) Pikesville Balto Co Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert J. [illegible] | |
| 25C. FUNERAL DIRECTOR Burgess Funeral Home | | ADDRESS Balto Md | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

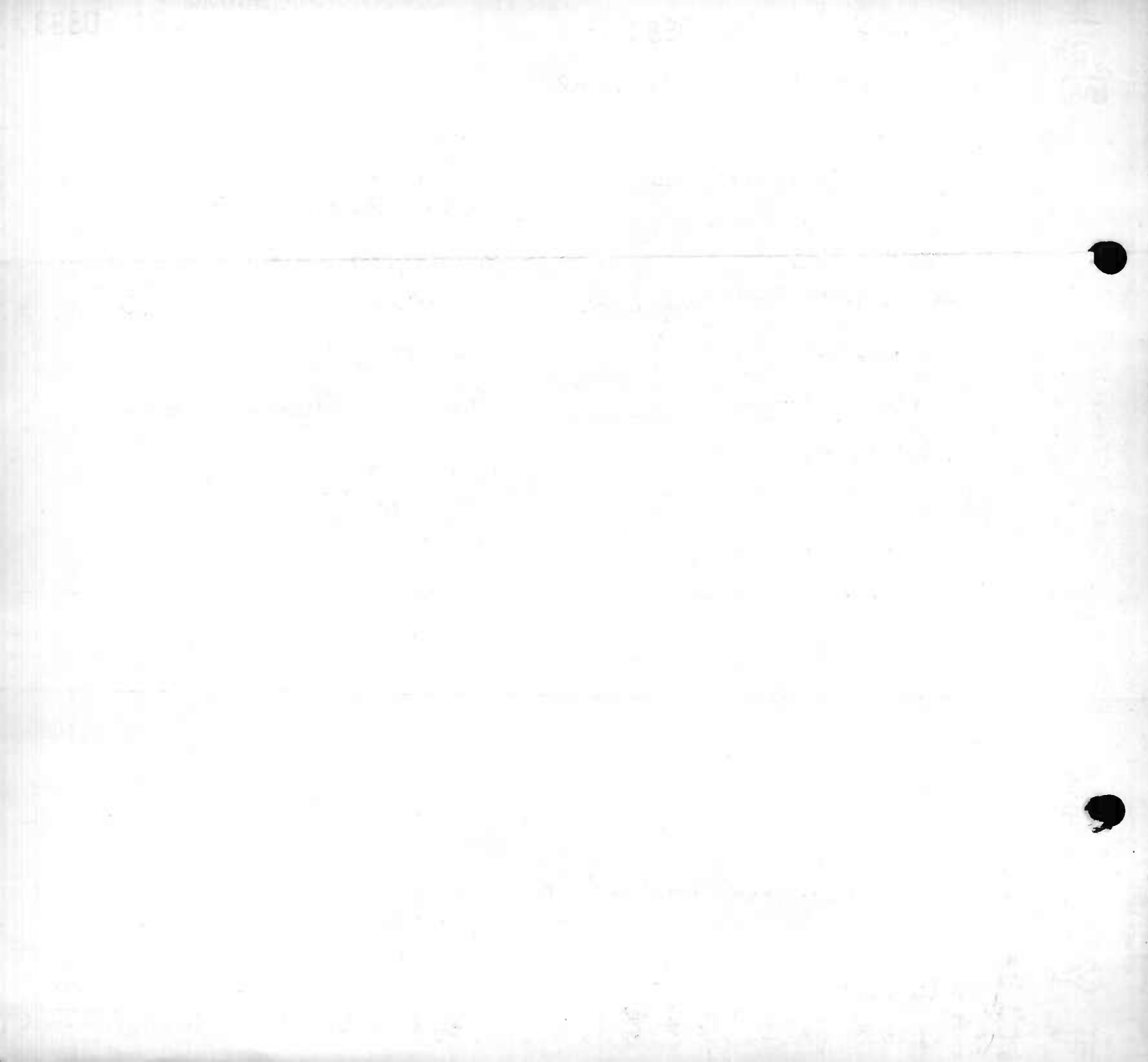
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0882 |
|---|--|--|--|-------------------------|
| B-625 71 0882 BIRTH NO. | | 71 0882 REG. NO. | | |
| 1. NAME OF DECEASED (Type or Print) Mabel I Burkins | | 2. DATE AND HOUR OF DEATH JAN 22 1971 7:30 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4231 Hickory Heights Ave | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) MD | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 4231 Hickory Heights Ave | | 5. CITY OR TOWN Baltimore | | |
| 6. RACE Female White | | 7. DATE OF BIRTH JAN 5 1895 | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. AGE (In years last birthday) 76 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | | 10B. KIND OF BUSINESS OR INDUSTRY Laundry | | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13. FATHER'S NAME Charles Edward Burkins | | 14. MOTHER'S MAIDEN NAME Elma E Lovett | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216 242470 | | |
| 17. INFORMANT Elma M Pomeroy | | ADDRESS 34 G/2vin Way | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 440.9 I | | CAUSE OF DEATH Interosclerosis | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 1960 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 1960 to January 22 1971 that (I) (we) last saw the deceased alive on January 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Wm G Helfrich MD | | 23B. DATE SIGNED 1-23-71 | | |
| 23C. PHYSICIAN'S NAME (Type) Wm G Helfrich | | 23D. ADDRESS 5006 Roland Ave. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-25-71 | | |
| 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem | | 24D. LOCATION (City, town, or county) (State) Pikesville Baltimore Co Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1971 | | 25B. NAME OF REGISTRAR Robert E. [unclear] | | |
| 25C. FUNERAL DIRECTOR Borger Funeral Home | | ADDRESS Baltimore Md | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|---|--|--|---|--|---|-----------------------|--|--|
| 71 0883 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0883 | | | | | |
| BIRTH NO. S-260 | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) LEON J. SUGAR | | | | | 2. DATE AND HOUR OF DEATH JAN 25, 1971 M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2740 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6222 BENHURST RD | | | | | C. CITY OR TOWN BALTO | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | E. STREET AND NUMBER 6222 BENHURST RD | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov 24, 1903 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret | | 10B. KIND OF BUSINESS OR INDUSTRY merchant | | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME Jacob | | | | | 14. MOTHER'S MAIDEN NAME Hattie | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Ida Sugar | | | ADDRESS Same | | | |
| 18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASHD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes | | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHD (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes (C) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25 1971 to 1/25 1971 , that (I) (we) last saw the deceased alive on 1/25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Donald W. [Signature] | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/27/71 | | 24C. NAME of CEMETERY or CREMATORY Hebrew Friendship | | 24D. LOCATION (City, town, or county) (State) Balto MD | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR John C. [Signature] | | 25C. FUNERAL DIRECTOR John C. [Signature] | | ADDRESS 9610 Reisterstown Rd | | | | |



K 32-3

31/99

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0884 | |
|--|--|--|--|------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. <u>D-220</u> <u>KOUTSOUDAKIS</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) THEODORE DAKIS (KOUTSOUDAKIS) | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 23, 1971 | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA) | | | 3. DATE PRONOUNCED DEAD Month Day Year January 23, 1971 4:50 P.M. | | |
| 6. SEX Male | | | 7. RACE White | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | C. CITY OR TOWN Baltimore | | |
| 10. AGE (In years lost birthday) 3-22-96 74 | | | E. STREET AND NUMBER 1845 Merritt Boulevard | | |
| 11. BIRTHPLACE (State or foreign country) Turkey | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 14B. KIND OF BUSINESS OR INDUSTRY Road constr. | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 17. SOCIAL SECURITY NO. 213-07-6467A | | |
| 18. INFORMANT Mrs. Agnes Dakis | | | ADDRESS 1845 Merritt Blvd., Baltimore, Md. | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 20A. DATE OF OPERATION | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 22F. HOW DID INJURY OCCUR? | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Ronald E. Kornblum M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) Ronald E. Kornblum, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-27-71 | | |
| 24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | 25B. NAME OF REGISTRAR Robert E. Feltz, M.D. | | |
| | | | 25C. FUNERAL DIRECTOR Nicholas T. Matthews | | |
| | | | ADDRESS 3021 Eastern Ave., Baltimore, Md. | | |

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MAY 1881

Nicholas P. ...
Kullback ...

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No. ...

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H-163

71 0885 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0885

BIRTH NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) Ann Mary Hubbard | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 25 71 3:35 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 613 N. Castle St. 3-15-71 | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 25 71 3:35 a. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 604 | | | |
| 6. SEX female | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 7/4/17 | | 10. AGE (In years lost birthday) 53 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer | | 14B. KIND OF BUSINESS OR INDUSTRY Gibbs & Co. | |
| 15. MOTHER'S MAIDEN NAME unknown | | 13. FATHER'S NAME Zahradka | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Lawrence Hubbard, husband, above | | ADDRESS | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Carbon Monoxide Intoxication | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) Home | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 613 N. Castle St. | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 1-25-71 Unk. m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Faulty heater | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 1/25/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR John E. [illegible] | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 2601 E. Madison St. | |

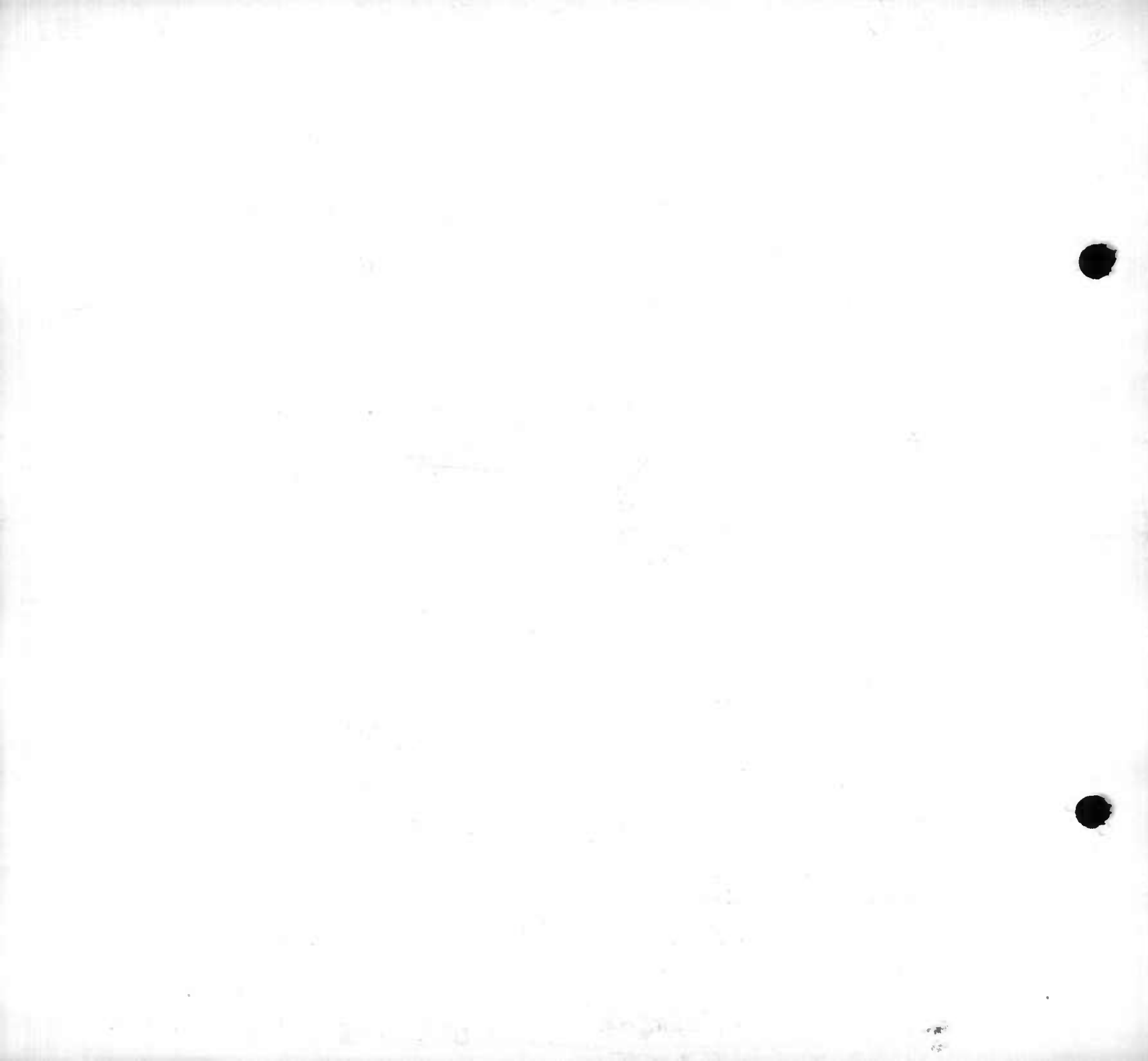
Letter from M.E.'s office
" " " "

3-15-71 M.H.
3-24-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| H-100 | | 71 0886 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0886 | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) Emma Hoppe | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH 1/24/71 8:30 P.M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt. City 2745 | | | |
| 5. SEX F | | | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 8. DATE OF BIRTH 01-21-80 | |
| 13. FATHER'S NAME Schmidt | | | | 14. MOTHER'S MAIDEN NAME Lindenberger Margaret Schmidt | | 9. AGE in years last birthday 90 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 215-05-5524D | | 17. INFORMANT Robert C. Hoppe, son, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E887X | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Fx @ Hip | | 3 weeks | |
| 19A. DATE OF OPERATION 1/10 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx Hip | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) above 2745 | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 1/9/71 PM | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fall | | 22. I certify that (I) (this hospital) attended the deceased from 1/9 to 1/24 1971 that (I) (we) last saw the deceased alive on 1/24 1971 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Omar D. Crothers | |
| 23B. PHYSICIAN'S NAME (Type) Omar D. Crothers | | 23C. ADDRESS Union Memorial Hosp | | 23D. DATE SIGNED 1/24/71 | | 23E. ATTENDING PHYSICIAN Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/27/71 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR R. E. E. E. E. | | 25C. FUNERAL DIRECTOR Schamunek Funeral Home, Inc. | | 25D. ADDRESS 03331 Bredms Lane | |



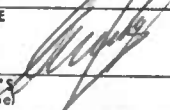
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

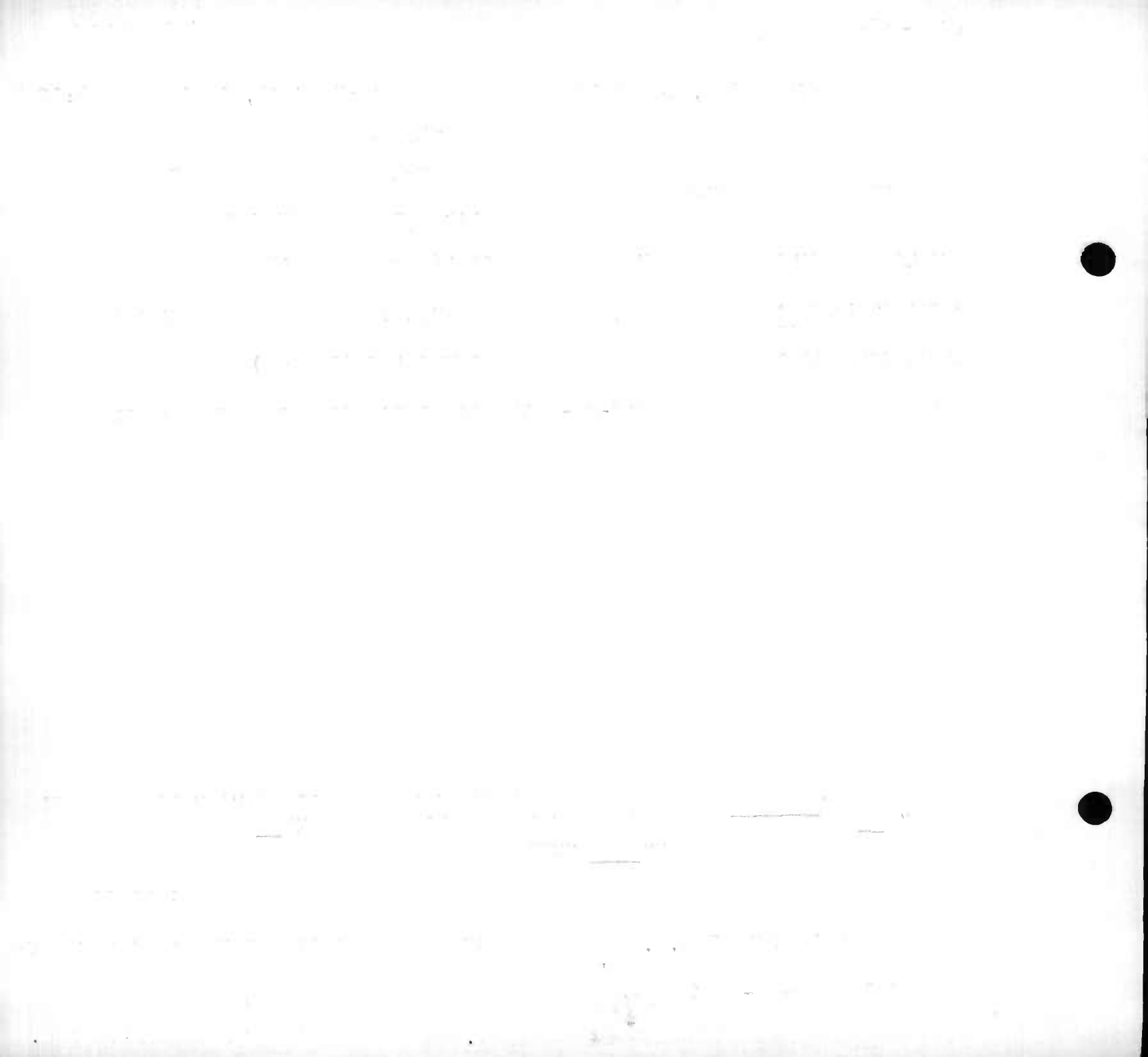
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|--|--------------|---|-----------------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 0887 | | 71 0887 | |
| S-530 | | 71 0887 | | 71 0887 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Clara Smith | | 1/26/71 8-45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland 1202 | |
| | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 3003 N. Charles St. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/2/94 | 9. AGE (In years last birthday) 76 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Department Store | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 13. FATHER'S NAME Julius Costella | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-10-1909A | | 17. INFORMANT David A. Smith | |
| | | ADDRESS 5648 Braxfield Rd | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1410.991 019.0 | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia M.I. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Old Pul. T.B. | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/12/1970 to 1/26/1971 that (I) (we) last saw the deceased alive on 1/19/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE K. L. W. I. M. D. | | 23B. DATE SIGNED 1/26/71 | | 23C. PHYSICIAN'S NAME (Type) K. L. W. I. M. D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/71 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR O. O. A. B. S. T. I. N. G. | | 25C. FUNERAL DIRECTOR A. B. S. T. I. N. G. | |
| | | 25D. ADDRESS 1328 Sulphur Sp. Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-516 71 0888 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71-0888 | |
|--|-------------------------|---|-------------------------------------|--|--|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) SCHAMBERG, LAWRENCE | | | | 2. DATE AND HOUR OF DEATH JANUARY 27, 1971 4:30 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2006 | | | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3128 STAFFORD STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 09 26 94 | 9. AGE (in years last birthday) 76 | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SAUSAGE | | | | 10B. KIND OF BUSINESS OR INDUSTRY Meat Packing Plant | | | |
| 13. FATHER'S NAME JOHN SCHAMBERG | | | | 14. MOTHER'S MAIDEN NAME CATHERINE (SHADER) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO | | | | 16. SOCIAL SECURITY NO. 215-09-9044 | | 17. INFORMANT ST AGNES RECORDS BALTO MD 21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Prob. Pul. embolism | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prob. Pul. embolism | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Obstructive Lung Disease | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 26 19 71 to JANUARY 27 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JANUARY 27 19 71 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED 01 27 71 | | | |
| 23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ M.D. | | | | 23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-30-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR G. Truman Schwab | | ADDRESS 3512 Frederick Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 0889</u> | |
|--|----------------------|--|--------------------------------|---|--|--|--|
| BIRTH NO. <u>K-614</u> | | 71 0889 | | 1. NAME OF DECEASED (Type or Print) <u>Kropfelder, Dorothy</u> | | 2. DATE AND HOUR OF DEATH <u>1/27/71 2:20 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Avenue</u> | | A. STATE <u>Maryland</u> | | B. COUNTY <u>Baltimore</u> | |
| CITY OR TOWN <u>Dundalk</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | E. STREET AND NUMBER <u>7372 Edsworth Road 21222</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-7-23</u> | 9. AGE (In years last birthday) <u>47</u> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Anthony Dopkowski, Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ann Augustyniak</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-12-5958</u> | | 17. INFORMANT <u>BCH RECORDS</u> ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u> | | | |
| 18. <u>394.0 I</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE <u>Cerebral anoxia</u> <u>48 hrs</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) <u>Cerebral vascular emboli</u> <u>4 days</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) <u>Rheumatic heart disease with mitral prothesis</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>1-23-71</u> <u>71</u> to <u>1-27-71</u> <u>71</u> that (1) (we) last saw the deceased alive on <u>1-27-71</u> <u>71</u> and that (1) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Russell Harris, M.D.</u> | | | | 23B. DATE SIGNED <u>1-27-1971</u> | | 23C. PHYSICIAN'S NAME (Type) <u>RUSSELL HARRIS</u> | |
| 23D. ADDRESS <u>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>1/30/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1971</u> | | 25B. NAME OF REGISTRAR <u>John J. Duda</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>7982 Wise Ave. Dundalk, Md.</u> | | | |

1947

825

On 10/10/47

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---------------------------------------|---|---|
| BIRTH NO. 5-361 71 0890 | | CERTIFICATE OF DEATH | | Registered No. 71 0890 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) George Strovel | | 2. DATE AND HOUR OF DEATH 1/26/71 930 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital | | D. STREET ADDRESS (If rural, give location) 4437 HARFORD RD | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married-Separated | B. DATE OF BIRTH 07-25-1891 | 9. AGE (In years last birthday) 79 | II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Balto. City Liquor Board | | 10B. KIND OF BUSINESS OR INDUSTRY Inspector | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Joseph Strovel | | 14. MOTHER'S MAIDEN NAME Elizabeth Miller | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-40-6420 | | 17. INFORMANT (Son) Baltimore, Maryland Frank Strovel 628 S. Linwood Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Aspiration pneumonia | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gastric Dilatation | | (B) Carcinomatous from Carcinoma Colon | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 1/21/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/15/71 to 1/26/71 and that (I) (we) last saw the deceased alive on 1/26/71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M.L.S. Brown, M.D. | | | | 23B. DATE SIGNED 1/26/71 | |
| 23C. PHYSICIAN'S NAME (Type) M.L.S. Brown, M.D. | | 23D. ADDRESS Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/71 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR John J. Duda | | 25C. FUNERAL DIRECTOR (Address) 2829 Hudson St. Balto. Md. | |

Male White
4432 HARROD 72
of 2210 72

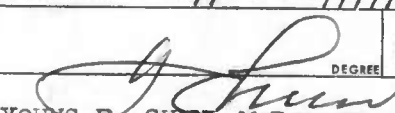
| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|---|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | REG. NO. |
| BIRTH NO. 71 0891 | | | |
| 1. NAME OF DECEASED (Type or Print) James L Brice | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 25 71 6:05 p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 7-16-1937 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years lost birthday) 33 32x | | E. STREET AND NUMBER 442 Patapsco Ave. | |
| 11. BIRTHPLACE (State or foreign country) Cass, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James E. Brice | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | |
| 15. MOTHER'S MAIDEN NAME Grace (Tallman) | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SECURITY NO. 216-34-9015 | | 18. INFORMANT Mr. James E. Brice same as # 5 | |
| 19. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | |
| (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2/21 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 5629 Torquay Rd. | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 1 25 71 5:51 pm | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? shot self | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-29-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Arborvale Cemetery | | 24D. LOCATION (City, town, or county) (State) Arborvale, W. Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR R. E. Labadie | |
| 25C. FUNERAL DIRECTOR McCully | | 25D. ADDRESS 237 Patapsco Ave. Balto. 21225 | |

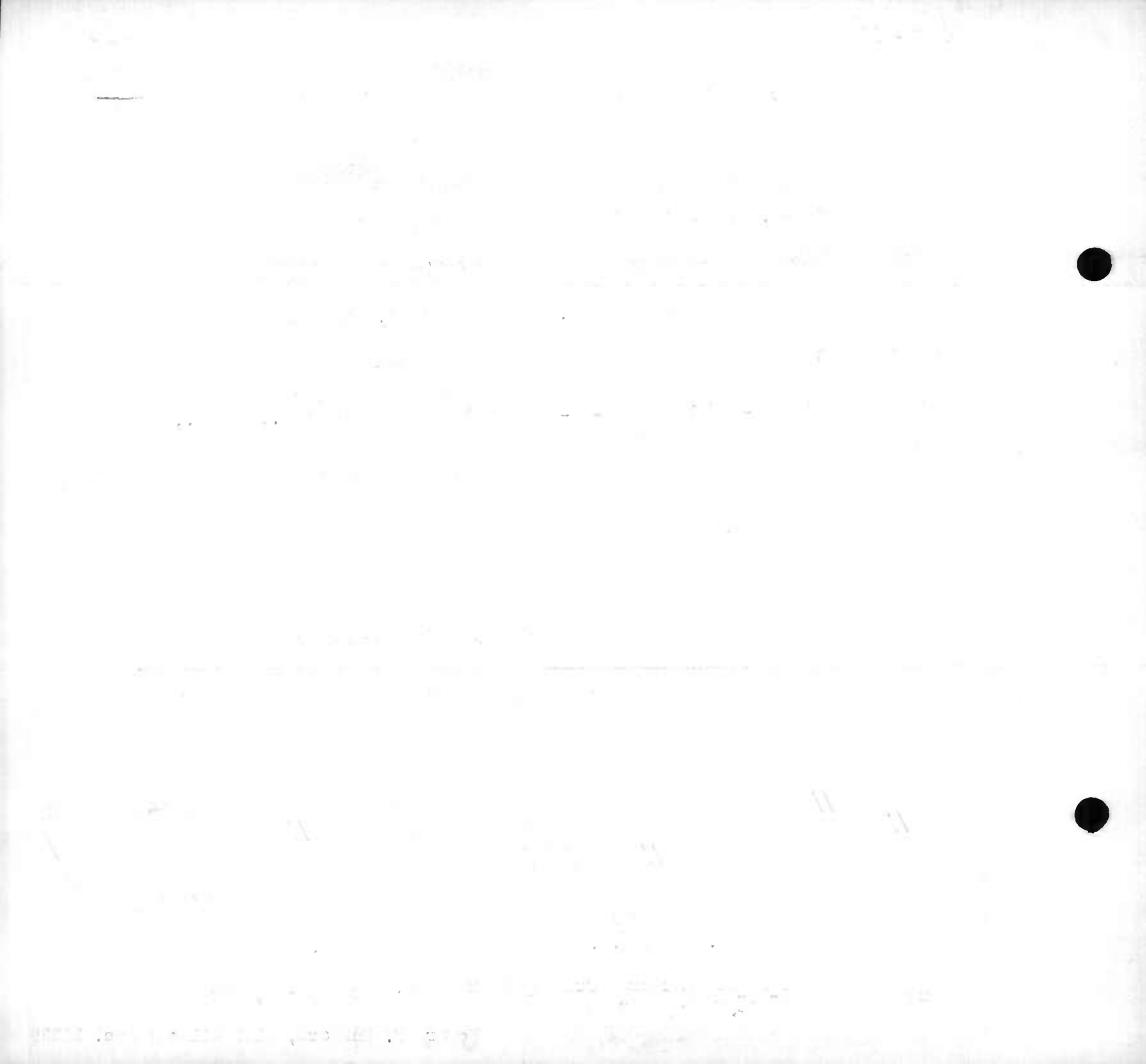
1981

ACADEMY BOOKS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

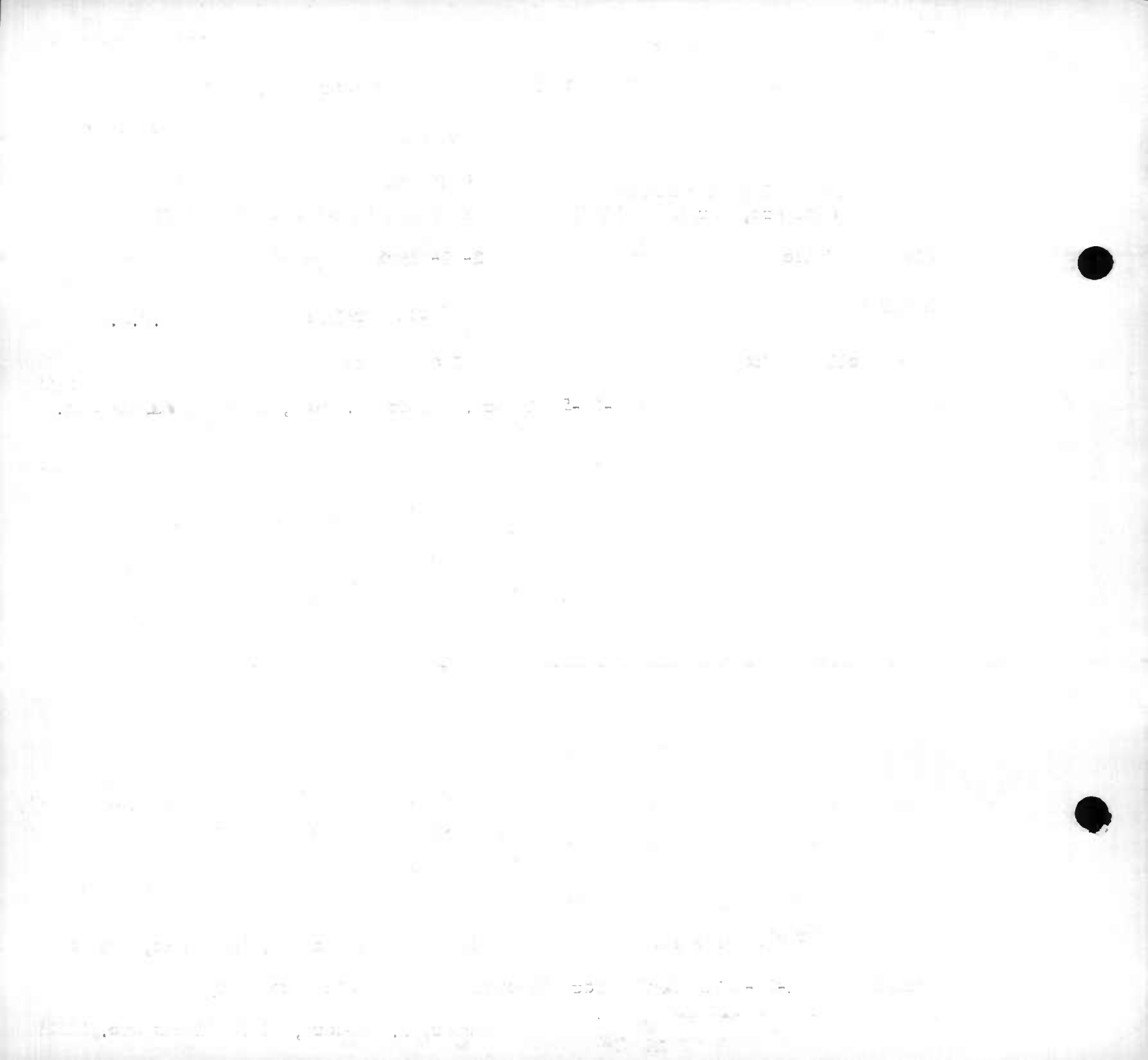
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0892 | |
|--|--|---|--|---|---|
| BIRTH NO. K-613 | | 71 0892 | | | |
| 1. NAME OF DECEASED (Type or Print) KRAFTY, Harold Albert | | | 2. DATE AND HOUR OF DEATH 1/25/71 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1606 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Male | | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 3/11/09 | | 9. AGE (In years last birthday) 61 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman | | 10B. KIND OF BUSINESS OR INDUSTRY Insurance Co. | | 11. BIRTHPLACE (State or foreign country) St Cloud, Minnesota | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Joseph Krafty | | |
| 14. MOTHER'S MAIDEN NAME Anna Powell | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 11/28/32 - 7/22/45 | | |
| 16. SOCIAL SECURITY NO. 214-26-4629 | | 17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I Carcinoma of lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Arteriosclerotic heart disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that 11 (this hospital) attended the deceased from September 3rd 19 71 to January 25th 19 71 that 11 (we) last saw the deceased alive on January 25th 19 71 and that in 11 (my) (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE  YOUNG E. CHUN, M.D. | | | | | 23B. DATE SIGNED 1/26/71 |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-29-71 | | 24C. NAME OF CEMETERY OR CREMATORY Lutheran Trinity Church Cem. | |
| 24D. LOCATION (City, town, or county) (State) Taneytown, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | |
| 25B. NAME OF REGISTRAR Robert C. Talley, M.D. | | 25C. FUNERAL DIRECTOR Howard M. Hubbard, 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

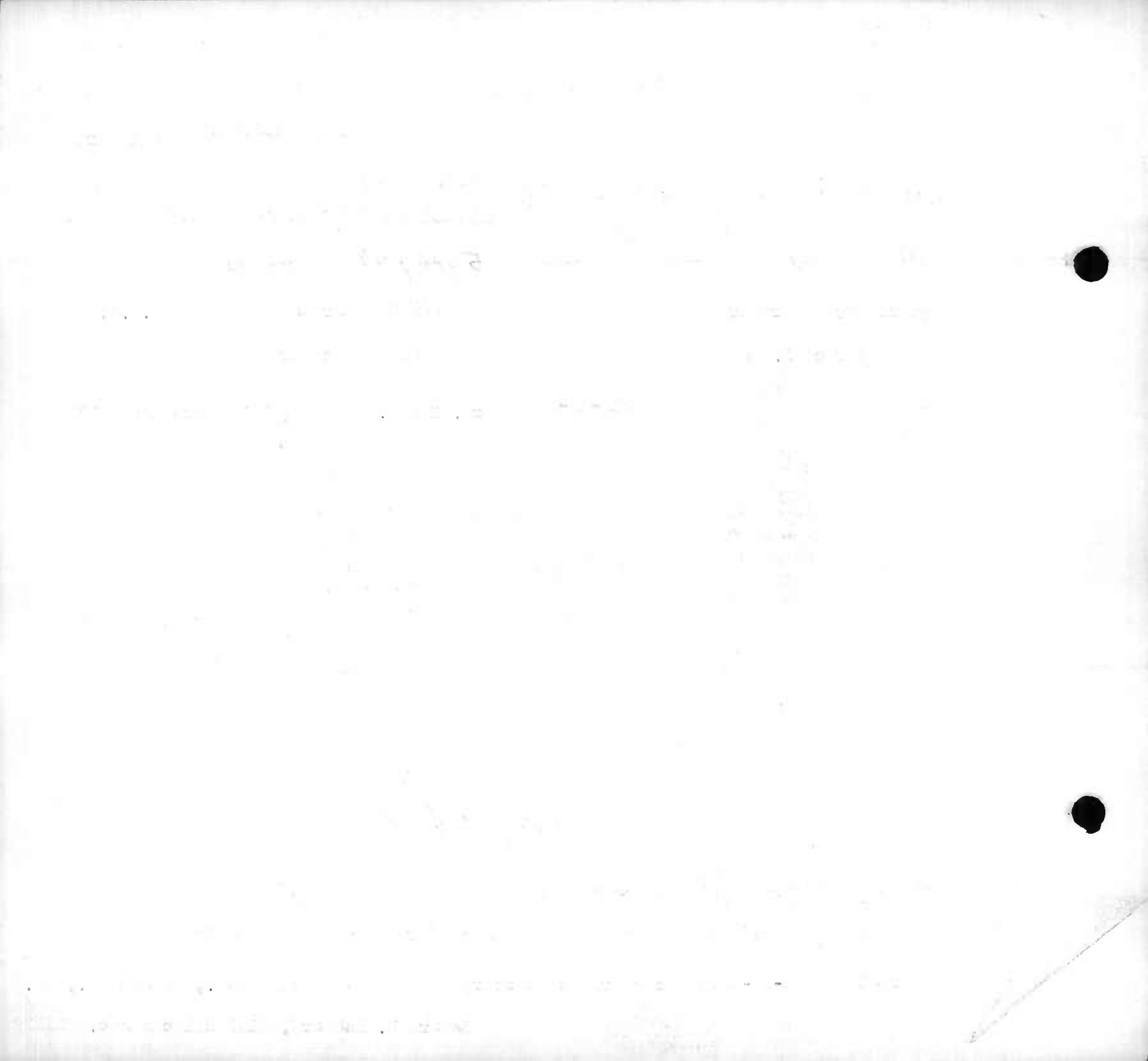
| | | | | | |
|---|------------------|---|--|---------------------------------------|--|
| <h2 style="margin: 0;">G-600</h2> | | <h2 style="margin: 0;">71 0893</h2> | <h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> | | <h2 style="margin: 0;">71 0893</h2> |
| BIRTH NO. REG. NO. | | | <h1 style="margin: 0;">CERTIFICATE OF DEATH</h1> | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH January 26, 1971 | | |
| EXUM DON GRAY | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1039 Wilmington Avenue Baltimore, Maryland 21223 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland 2582 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1039 Wilmington Avenue 21223 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-1-1902 | 9. AGE (in years last birthday) 68 | 10. If Under 1 Yr. Months: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 13. FATHER'S NAME Roswell Gray | | | 14. MOTHER'S MAIDEN NAME Ida Moore | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 244-26-5861 | | |
| | | | 17. INFORMANT Mrs. Mildred M. Gray, 1039 Wilmington Ave. | | |
| | | | ADDRESS 21223 | | |
| 18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ascvd</u> <u>Coronary occlusion</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Ascvd x Emphysema</u> (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>years</u> |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>8-6-1968</u> to <u>1-26-1971</u> that (2) (we) last saw the deceased alive on <u>1-3-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Hiroshi Nakazawa</u> | | | 23B. DATE SIGNED <u>1-26-71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) Hiroshi Nakazawa | | | 23D. ADDRESS 3350 Wilkens Avenue, Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-28-1971 | | |
| 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | 25B. NAME OF REGISTRAR Howard H. Hubbard | | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard | | | ADDRESS 4107 Wilkens Ave. 21229 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

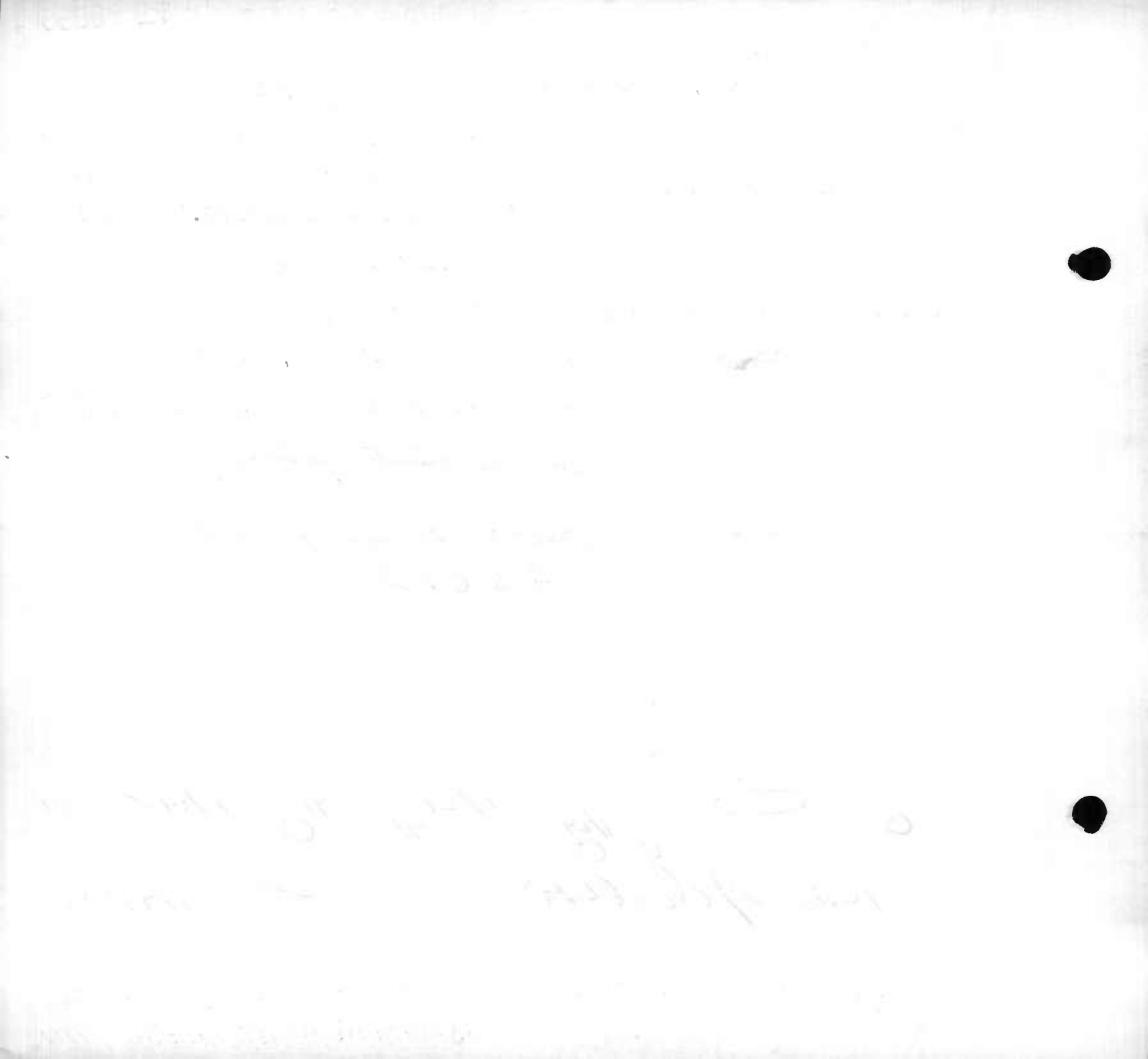
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|---|---|---|--|--|--|---|
| 71 0894 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0894 | | | | |
| 1. NAME OF DECEASED (Type or Print) SCHWINK, FREDERICK W. | | | | | 2. DATE AND HOUR OF DEATH 1/26/71 11:45 P.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of MD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN B Lansdowne D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2920 BERO ROAD | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/12/98 | 9. AGE (In years last birthday) 72 yrs | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Driver | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13. FATHER'S NAME George J. Schwink | | | | | 14. MOTHER'S MAIDEN NAME Mary Mengerson | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 215-10-5659 | | 17. INFORMANT Mrs. Iva R. Schwink, 2920 Bero Road 21227 | | | | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE CORONARY OCCLUSION (SUSPECT) ARTERIO SCLEROTIC HEART DISEASE ADVANCED PULMONARY EMPHYSEMA. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? NO INJURY | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25/71 to 1/26/71 and that (I) (we) lost saw the deceased alive on 1/26/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE R George Thomas MD | | | | | 23B. DATE SIGNED 1/26/71 | | | 23C. PHYSICIAN'S NAME (Type) R GEORGE THOMAS MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 1-30-1971 | | | 24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | | 24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co., Md. |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor MD | | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | | | |
| | | | | | | ADDRESS 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. |
|--|--|--|--|----------|
| M-633 71 0895 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Meredith, James MELVIN | | 2. DATE AND HOUR OF DEATH 1/24/71 12:05 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MARYLAND B. COUNTY CARROLL Co. C. CITY OR TOWN WESTMINSTER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 194 Washington Rd. (Westminster) | | 5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 08/13/94 9. AGE (In years last birthday) 76 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICIAL BOTTLING Co. 10B. KIND OF BUSINESS OR INDUSTRY COCA-COLA 11. BIRTHPLACE (State or foreign country) PULASKI Co. VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Thomas NELSON MEREDITH | | 14. MOTHER'S MAIDEN NAME Griffith, Mary ANN | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W. W. I. | | 16. SOCIAL SECURITY NO. 214-16-0215 | | |
| 17. INFORMANT MRS. MABEL CREST MEREDITH | | ADDRESS 194 WASH. ROAD WESTMINSTER, MD. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Chronic obstructive pulmonary DUE TO, OR AS A CONSEQUENCE OF: (B) die 2° chronic bronchitis DUE TO, OR AS A CONSEQUENCE OF: (C) A5CVD | | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/21 1971 to 1/24 1971 that (I) (we) last saw the deceased alive on 1/24 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE 23C. PHYSICIAN'S NAME (Type) | | 23B. DATE SIGNED 1/24/71 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-27-71 | | |
| 24C. NAME of CEMETERY or CREMATORY WESTMINSTER CEMETERY | | 24D. LOCATION (City, town, or county) (State) WESTMINSTER, CARROLL Co. Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | |
| 25C. FUNERAL DIRECTOR JO 28 Myers, Jr. | | ADDRESS Westminster, Md. | | |



W-426

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0896

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

0896

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Lila Wilkerson | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 17 Year 71 Hour 8:58 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD Month 1 Day 17 Year 71 Hour 8:58 p.m. | |
| 6. SEX female | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 807 | |
| 9. DATE OF BIRTH 4-13-1892 | | 10. AGE (In years last birthday) 78 | |
| 11. BIRTHPLACE (State or foreign country) Oxford, N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Woodson Hunt | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | |
| 15. MOTHER'S MAIDEN NAME UNKNOWN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Jennie Hawkins | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | DATE SIGNED 1/18/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 1-21-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Belton Creek Cemetery | | 24D. LOCATION (City, town, or county) (State) Oxford, N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 23 1971 | | 25B. NAME OF REGISTRAR Robert E. [unclear] | |
| 25C. FUNERAL DIRECTOR Rudolph J. Collick | | ADDRESS 2431 E. Oliver St. | |

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UNITED STATES DEPARTMENT OF THE INTERIOR

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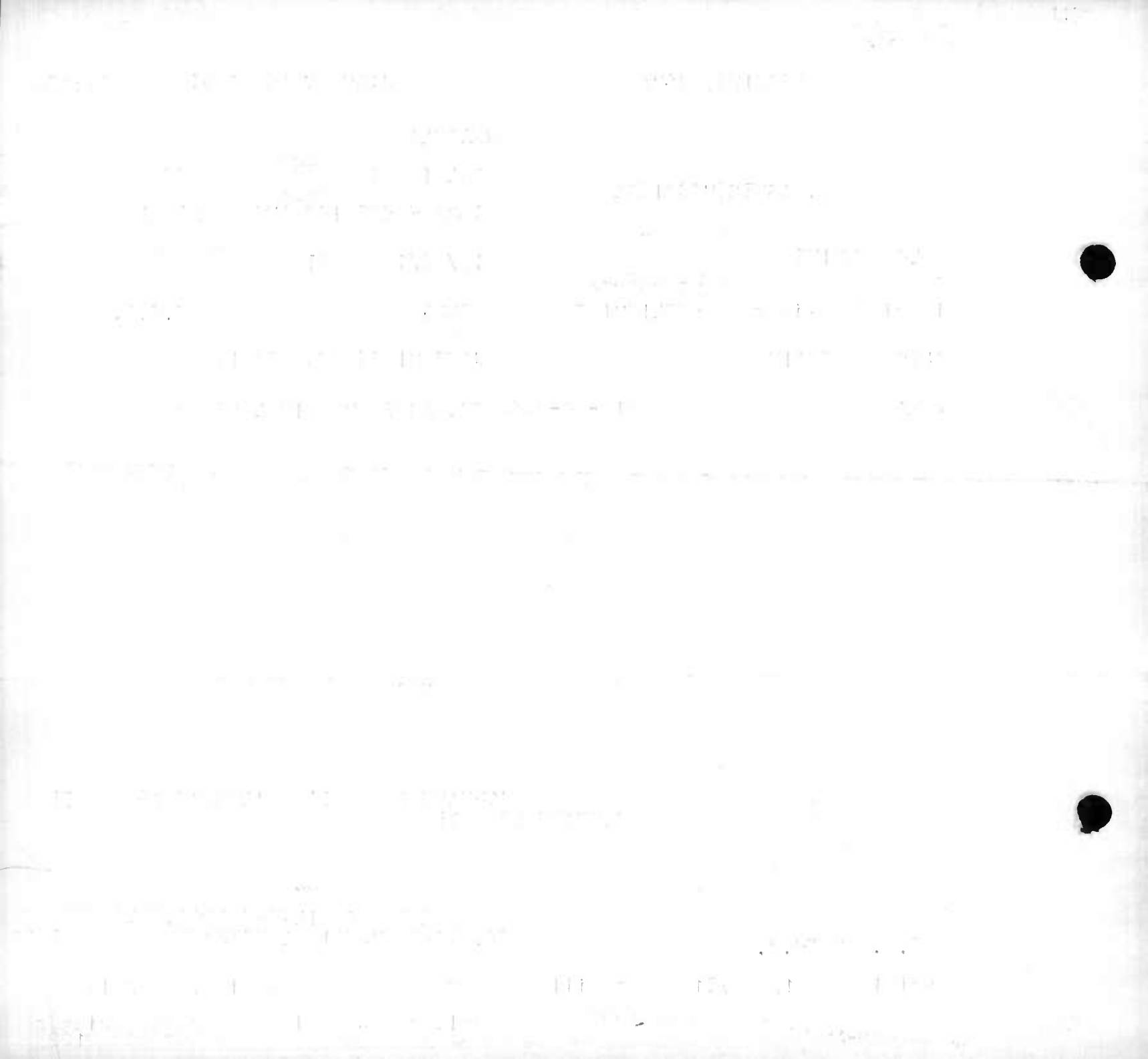
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | REG. NO. <u>0897</u> | |
|--|--|--|--|---|--|-------------------------------------|--|---|--|---|--|
| BIRTH NO. <u>R-231</u> | | 71 0897 | | | | CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>RESTIVO, JOHN</u> | | | | | 2. DATE AND HOUR OF DEATH <u>JANUARY 26, 1971</u> <u>11:25A</u> M. | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1903</u> | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u> | | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | E. STREET AND NUMBER <u>1823 FREDERICK AVE</u> | | | 21223 | | | |
| 5. SEX <u>MALE</u> | | 6. RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/06/19</u> | | 9. AGE (in years last birthday) <u>51</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>District Adviser</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER PUBLISHING</u> | | | 11. BIRTHPLACE (State or foreign country) <u>PENNA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>GIACOMO RESTIVO</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>JOSEPHINE (DUCA) RESTIVO</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u> | | | | | 16. SOCIAL SECURITY NO. <u>219-05-5968</u> | | 17. INFORMANT <u>ST. AGNES HOSPITAL RECORDS</u> | | | | |
| 18. <u>432.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EDEMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CEREBRAL ANGIOA AND EDEMA</u> <u>SURGICAL MANIPULATION, CAROTID ARTERY</u> | | | | | CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u> <u>24 HRS.</u> <u>24 HRS.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>GENERALIZED SEVERE ATHEROSCLEROSIS</u> | | | | | YEARS | | | | | | |
| 19A. DATE OF OPERATION <u>1/13/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CAROTID ARTERY DILATATION</u> | | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 3</u> 19 <u>71</u> to <u>JANUARY 26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>JANUARY 26</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | | DEGREE | | | 23B. DATE SIGNED <u>1/26/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>F. N. BURTMAN</u> | | | | | DEGREE | | | 23D. ADDRESS <u>CATON & WILKENS AVES. BALTO, MD</u> <u>ST. AGNES HOSPITAL RECORDS</u> 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1/29/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Maryland</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u> | | | 25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u> | | | ADDRESS <u>Pratt & Stricker Streets 21223</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-340 71 0898 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0898 | |
|--|-------------------------|---|-------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. <i>North Carolina</i> | | 2. DATE AND HOUR OF DEATH <i>1/18/71 12:20 am</i> | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Lynette Battle</i> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore Inc.</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Belvedere Ave. at Greenspring 21215</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i> | |
| | | C. CITY OR TOWN <i>BALTIMORE</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <i>4010 Belvidere Ave 21215</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>BLACK</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12/28/69</i> | 9. AGE (In years last birthday) <i>1</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N/A</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>N/A</i> | | 11. BIRTHPLACE (State or foreign country) <i>North Carolina</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>US</i> | | 13. FATHER'S NAME <i>Michael Anthony Battle</i> | | 14. MOTHER'S MAIDEN NAME <i>Bethie Battle</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>IN2 Phillips Balt. Md</i> | |
| 18. <i>751.5 I</i> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</i> | | (A) IMMEDIATE CAUSE <i>Hemorrhage, GIT, CNS</i> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Complete Biliary Atresia</i> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) <i>—</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>II</i> | | <i>Congestive Heart Failure; Septic</i> | | | |
| 19A. DATE OF OPERATION <i>—</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> | | 20A. AUTOPSY? (Yes or No) <i>—</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>—</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>—</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/16</i> 19 <i>71</i> to <i>1/18</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>1/18</i> 19 <i>—</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Largula M.O.</i> | | 23B. DATE SIGNED <i>1/18/71</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Opheka Larnula M.O.</i> | | 23D. ADDRESS <i>Sinai Hosp. of Balt.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1-24-71</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Brooklyn Cemetery</i> | |
| 24D. LOCATION <i>Nashville</i> | | 24E. LOCATION (City, town, or county) (State) <i>Nashville, Tenn.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1971</i> | | 25B. NAME OF REGISTRAR <i>—</i> | | 25C. FUNERAL DIRECTOR <i>—</i> | |
| 25D. ADDRESS <i>Baltimore, Md.</i> | | | | | |

James Black

1/10

1/10

James Black

James Black

James Black

James Black

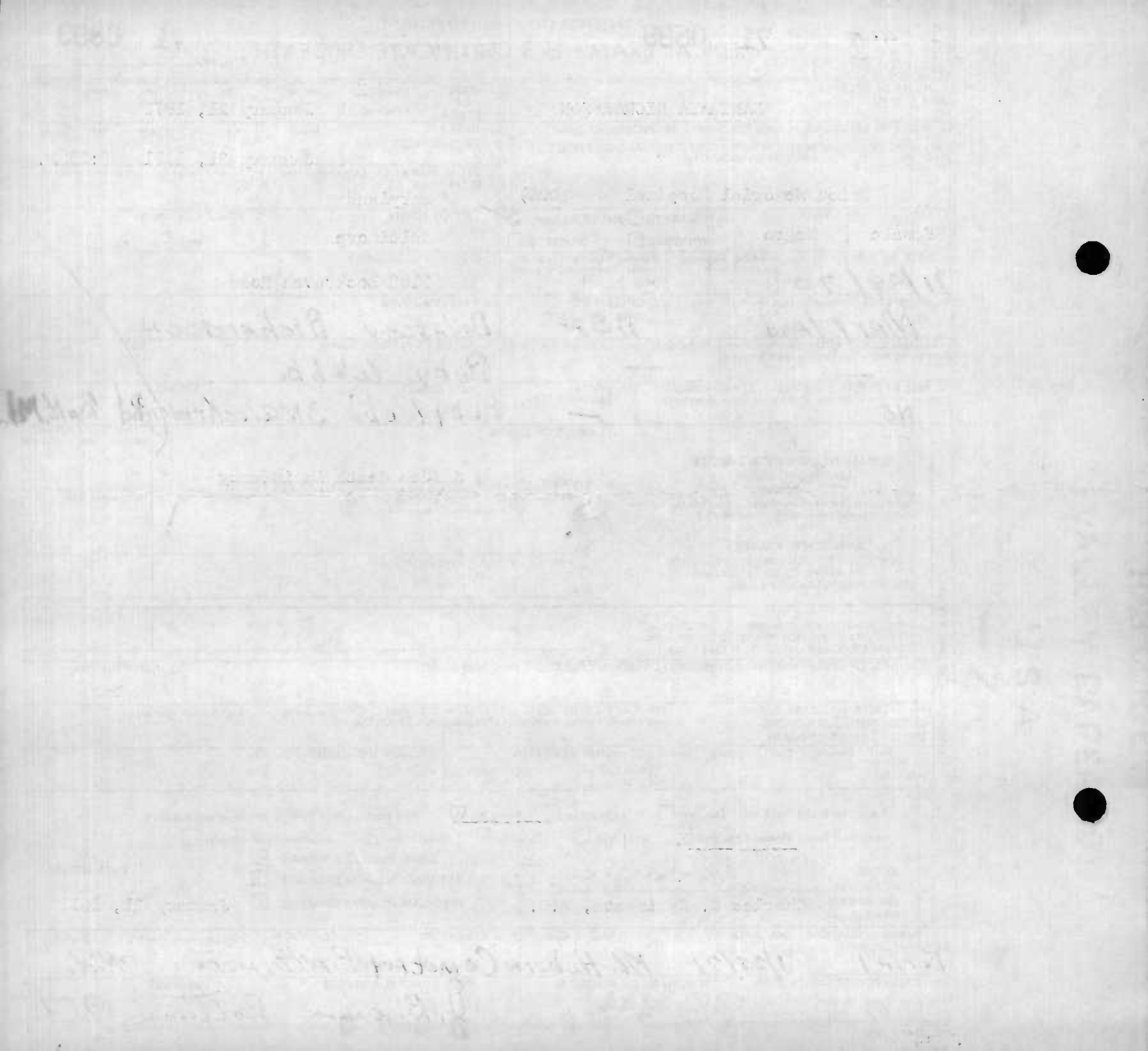
James Black

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James Black

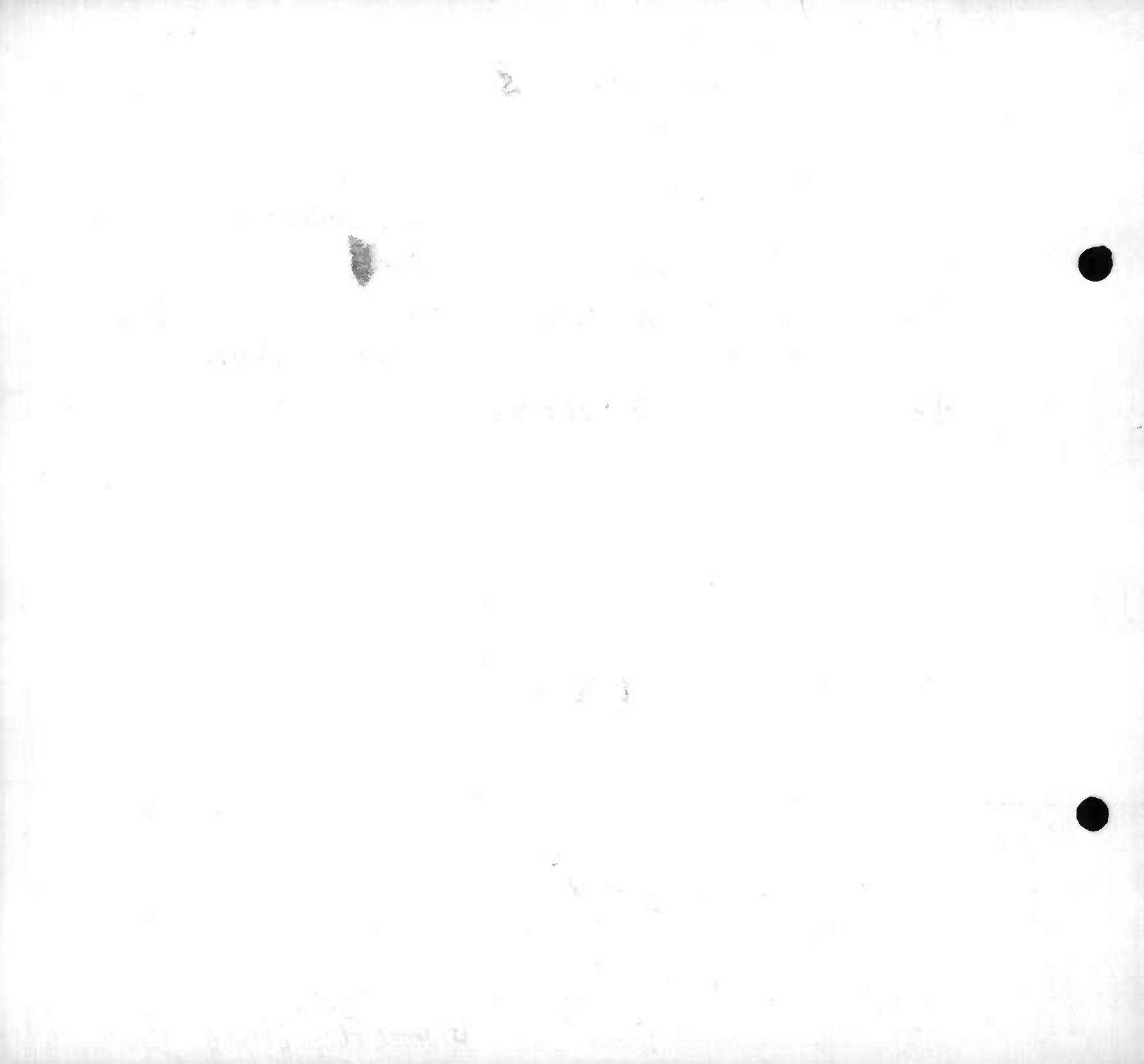
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0899 | |
|---|----------------------------------|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | |
| SANTRAYA RICHARDSON | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year January 21, 1971 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 6. TIME OF DEATH | |
| (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Union Memorial Hospital (DOA) | | Maryland | | 905 | |
| 6. SEX | 7. RACE | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | C. CITY OR TOWN | D. INSIDE CITY LIMITS? | |
| Female | Negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH | 10. AGE (In years last birthday) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| 11/28/70 | 21 | Maryland | USA | | |
| 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| Delancy Richardson | | 15. MOTHER'S MAIDEN NAME | | | |
| Ruby Webb | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| NO | | 17. SOCIAL SECURITY NO. | | | |
| 18. INFORMANT | | 19. CAUSE OF DEATH | | | |
| Ruby Webb | | 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| 3102 Lockraven Rd Baltimore | | (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | |
| | | (A) IMMEDIATE CAUSE Sudden death in infancy | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) _____ | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) _____ | | | |
| | | II | | | |
| | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | |
| 21 | | | | Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED | | 22F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| | | | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | January 21, 1971 | |
| Charles S. Springate, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 1/25/71 | MD. Auburn Cemetery | Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | ADDRESS | | |
| JAN 29 1971 | Robert E. [illegible] | J. B. [illegible] | Baltimore, Md. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

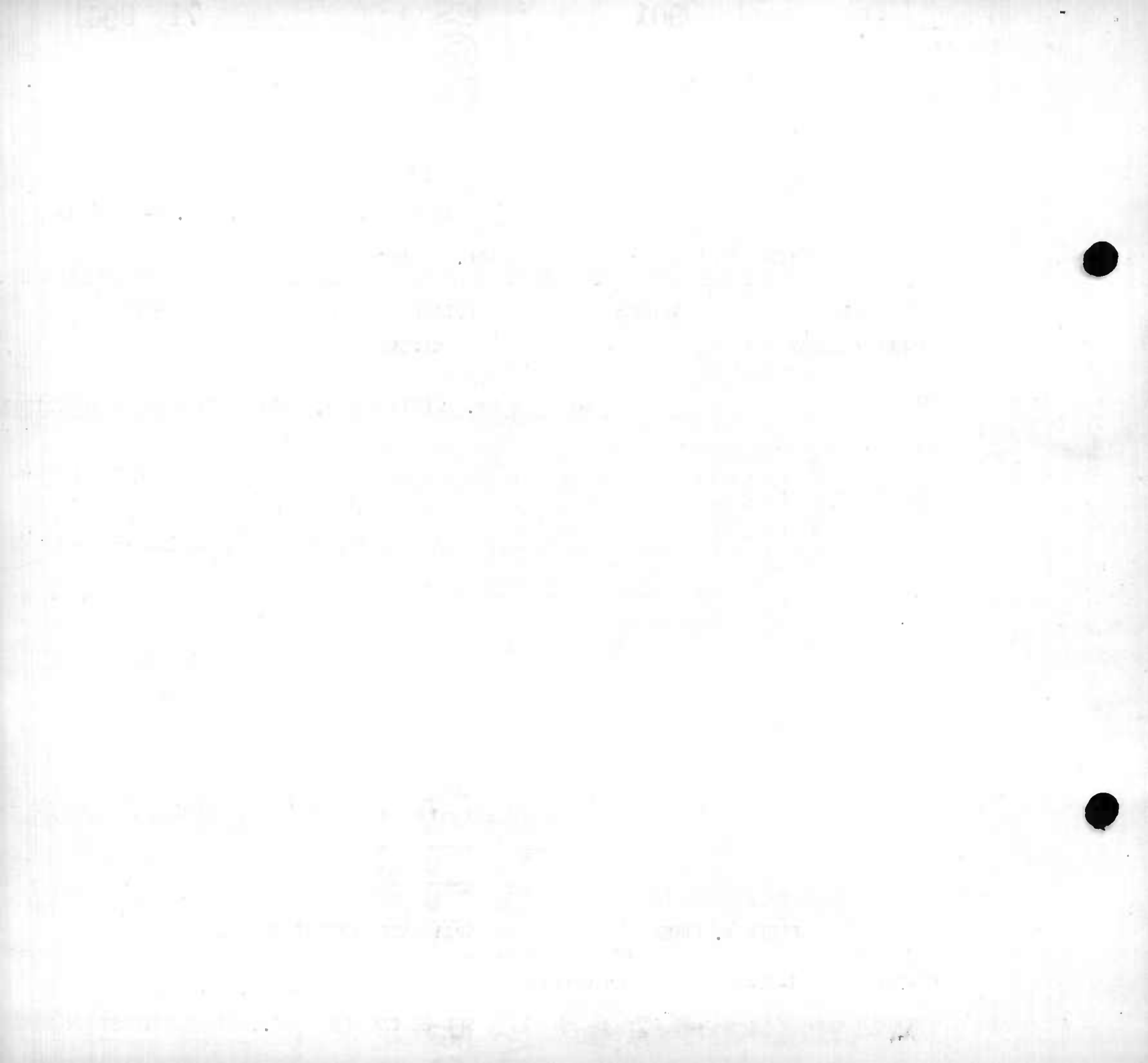
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0900 | | | |
|---|-------------------------|---|--|---|--|--|------------------------|
| K-412 71 0900 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Kelbaugh, Lillian I. | | | | 2. DATE AND HOUR OF DEATH 1. 27-71 4.10 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MARYLAND | | B. COUNTY | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3539 ROLAND AVEN. APT. 712 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 03-28-01 | 9. AGE (in years last birthday) 69 | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Worker Country Club | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME DAVID WILLIAM STANBAUGH | | | |
| 14. MOTHER'S MAIDEN NAME CATHERINE PHIPPS | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - | | | |
| 16. SOCIAL SECURITY NO. 217 077379A | | | | 17. INFORMANT GRACE STANBAUGH | | | |
| 18. 4.10.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease | | | |
| | | | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Int/43 | | | | | | | |
| 19A. DATE OF OPERATION 1. 27-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal of gallbladder | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1. 27-71 19 to 1. 27-71 19 that (I) (we) last saw the deceased alive on 1. 27-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Mahmood Ali Khan | | | | 23B. DATE SIGNED 1. 27. 71. | | 23C. PHYSICIAN'S NAME (Type) MAHMOOD ALI KHAN | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 30 JAN 71 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem | | 24D. LOCATION (City, town, or county) (State) Pikesville B. H. Co. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR 2. 6. 68 2. 6. 71 | | 25C. FUNERAL DIRECTOR Burger Funeral Home | | ADDRESS Balto, Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0901 | |
|---|------------------|---|-------------------------------|---|---|
| A-320 | | 71 0901 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | TILLIE ADDIS | | 2. DATE AND HOUR OF DEATH JANUARY 26, 1971 9 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SNAI HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | MARYLAND <i>Baito.</i> 5300 | |
| C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 15 COBBLESTONE COURT, APT. T-1 #21215 | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 1904 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME ASHER ADELMAN | | 14. MOTHER'S MAIDEN NAME EXTREX X GITTEL ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT MR. MELVIN ADDIS, 6820 HUNTINGTON DRIVE #21207 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary occlusion</i> (B) <i>Coronary artery disease</i> (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Annals</i> <i>9 yrs</i> | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Oct 1971</i> to <i>Jan 1971</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Joseph B. Gross</i> | | 23B. DATE SIGNED <i>Jan 27/1971</i> | | 23C. PHYSICIAN'S NAME (Type) JOSEPH B. GROSS | |
| 23D. ADDRESS 6911 PARK HEIGHTS AVENUE | | 23E. ADDRESS 6911 PARK HEIGHTS AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-27-71 | | 24C. NAME OF CEMETERY or CREMATORY RUDOMER VEREIN | |
| 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR <i>Rebecca...</i> | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 0902 | | 71 0902 | |
| BIRTH NO. G-430 | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) William Gold | | | 2. DATE AND HOUR OF DEATH Jan. 26, 1971 8:05 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore, Inc. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5000 Pennsylvania Avenue F. LEVINDALE HEBREW HOME | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 1883 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR | | 10B. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE SALES | | 11. BIRTHPLACE (State or foreign country) AUSTRIA | |
| 13. FATHER'S NAME HYMAN GOLD | | | 14. MOTHER'S MAIDEN NAME LEAH ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MRS. LILLIAN LIPMAN, 6611 EBERLE DR., APT. 202 | |
| 18. 519.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Obstructive Pulmonary Disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from Jan. 4 1971 to Jan. 26 1971 that (H) (we) last saw the deceased alive on Jan. 26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dan Sunshine, M.D. | | | 23B. DATE SIGNED Jan. 26, 1971 | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) DAN SUNSHINE M.D. | | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE, INC. Belvedere & Greenspring Aves, BALTIMORE, MD. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-27-71 | | 24C. NAME OF CEMETERY OR CREMATORY AITZ CHAIM | |
| 24D. LOCATION (City, town, or County) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Talbot, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS SOO LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |

5/16/67 - 5010 Denmore Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 71 0903 | |
|---|--|-------------------------|--|---|--|---|--|---|--|--|--|
| M-246 71 0903 | | BIRTH NO. | | | | | | 1. NAME OF DECEASED (Type or Print) MISLER, JOSEPH | | 2. DATE AND HOUR OF DEATH 1/26/71 6.15 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY BALTIMORE | | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER EBERLE DRIVE 6618 | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/8/88 | | 9. AGE (in years last birthday) 82 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED | | | | 10B. KIND OF BUSINESS OR INDUSTRY BUILDER | | | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CHARLES MISLER | | | | | | 14. MOTHER'S MAIDEN NAME EVA ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 111-05-1608A | | 17. INFORMANT ADDRESS MRS. GUSTY MISLER, 6618 EBERLE DR. #21215 | | | | | |
| 18. 162.1 I CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) IMMEDIATE CAUSE ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: EMPHYEMA (B) DUE TO, OR AS A CONSEQUENCE OF: CANCER of LUNG (C) ARTERIOESCLEROSIS | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/18 19 70 to 1/26 19 71 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 1/25 19 71 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Alberto Colla M.D. DEGREE | | | | | | | | Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/26/71 | |
| 23C. PHYSICIAN'S NAME (Type) ALBERTO COLLA MD. DEGREE | | | | | | | | 23D. ADDRESS 2543 C Steele Rd. BALTIMORE Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 1-27-71 | | 24C. NAME OF CEMETERY or CREMATORY ANSHE NEISEN | | | | 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | | 25B. NAME OF REGISTRAR Robert E. SOD | | | | 25C. FUNERAL DIRECTOR ADDRESS SOD LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|---|---|
| <div style="display: flex; justify-content: space-between;"> S-600 71 0904 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 71 0904 </div> | | | |
| 1. NAME OF DECEASED (Type or Print) SERIO, JENNIE | | 2. DATE AND HOUR OF DEATH 01-28-71 9:00 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MD. 21229 | | C. CITY OR TOWN BALTIMORE, D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 2205 LUKEWOOD DRIVE 21207 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 01-19-91 |
| 9. AGE (In years last birthday) 80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 11. BIRTHPLACE (State or foreign country) ITALY |
| 12. CITIZEN OF WHAT COUNTRY? NOT A U.S. CITIZ | | | |
| 13. FATHER'S NAME VINCENT GLORIOSO DEC'D | | 14. MOTHER'S MAIDEN NAME ANNA DEC'D | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216-32-8531 | |
| 17. INFORMANT ST AGNES RECORDS | | ADDRESS WILKENS & CATON AVE | |
| 18. 250.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe uncontrollable ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus, MI. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years Possible weeks | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 12-18-70 to 1-28 19 71 that (2) (we) last saw the deceased alive on 1-28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Bizhan Ebrahmy MD | | 23B. DATE SIGNED 1/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) BIZHAN EBRAHMY MD | | 23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 2/1/71 | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Blaise E. J. [illegible] | |
| 25C. FUNERAL DIRECTOR Wizke, 1630 Edmondson Ave., 21228 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0905 | | REG. NO. 71 0905 | |
|---|---------|---|------------------|--|------------------------|--|-------------------------|
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ROSE ROVNER | | | | 1-17-71 3:00 P.M. 3:00 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 00 3010 Fallstaff Road | | | | 3010 Fallstaff Road, Baltimore, Md. | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 3010 Fallstaff Rd. 2730 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months | 11. UNDER 24 Hrs. Days | 12. UNDER 24 Hrs. Hours |
| Female | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Dec. 25, 1900 | 70 yrs. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Isaac Frankel | | | | Jennie Frankel | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | 218-32-5587B | | Dr. Frankel | |
| 18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE | | | |
| ANTECEDENT CAUSES | | | | Coronary Occlusion | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | Hypertensive C - V - Disease | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | Acute | | | |
| | | | | Years | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the physician) attended the deceased from October 19 64 to Jan. 17 19 71 that (I) (we) last saw the deceased alive on 1-17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Louis R. Maser M.D. | | | | 1/11/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Louis R. Maser M.D. | | | | 2724 Smith Ave., Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 1-18-71 | | Beth Tifloh | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 29 1971 | | E. J. Taylor, M.D. | | S. Van Lewis & Son | | Garrison, Md. | |



1/10/10

From the Museum of the
City of New York

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0906 |
|--|--------------------|---|-----------------------------|---|
| BIRTH NO. P-362 | | 71 0906 | | |
| 1. NAME OF DECEASED (Type or Print) | | Norman Peterson | | 2. DATE AND HOUR OF DEATH 1-27-71 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Md. 1703 | | |
| 00 832 Edmondson Ave. | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER 832 Edmondson Ave. | | |
| 5. SEX Male | 6. RACE Negroid | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-18-01 | 9. AGE (In years last birthday) 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired janitor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. |
| 13. FATHER'S NAME Thomas Peterson | | 14. MOTHER'S MAIDEN NAME Mary | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Ellen Peterson |
| | | ADDRESS | | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 6/18 1970 to Jan 27 1971 that (I) last saw the deceased alive on Jan 26 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE William H. Watts M.D. | | | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) William H. Watts | | | | 23D. ADDRESS 515 N. Arlington Ave Balto Md |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY |
| Burial | | 2-1-71 | | Mt. Auburn Cemetery |
| 25A. DATE RECD BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR V. Bailey | | 25C. FUNERAL DIRECTOR Nelson F.H. 1348 Calhoun St. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|---|---|---|--|
| BIRTH NO. <u>4-453</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71 0907</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>LEANDER T. HOLLAND</u> | | | 2. DATE AND HOUR OF DEATH <u>1/28/71</u> <u>14:30 A. M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>X6 LUTHERAN HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2717</u> | | |
| | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>5100 PALMER AVENUE</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-2-15</u> | 9. AGE (In years last birthday) <u>55</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>STATION-WIDE PLUMB.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> | | | 16. SOCIAL SECURITY NO. <u>219-03-1972</u> | | 17. INFORMANT <u>HELEN HOLLAND</u> ADDRESS <u>CHART 5100 PALMER AVE.</u> |
| 18. <u>431.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>CEREBRAL HAEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>HYPERTENSIVE VASCULAR DISEASE</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/27/1971</u> to <u>1/28/1971</u> that (I) (we) last saw the deceased alive on <u>1/28/1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>S. Basu</u> <u>M.D.</u> DEGREE | | | 23B. DATE SIGNED <u>1/28/71</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u> | | | 23D. ADDRESS <u>Lutheran Hospital of Maryland</u> DEGREE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-1-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>MT. AUBURN CEM.</u> | |
| 24D. LOCATION <u>BALTO. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Feltz, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Robert E. Feltz, M.D.</u> ADDRESS <u>345 N. Calhoun</u> | | | |

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Handwritten text, possibly a name or subject.

Handwritten text, possibly a signature or closing.

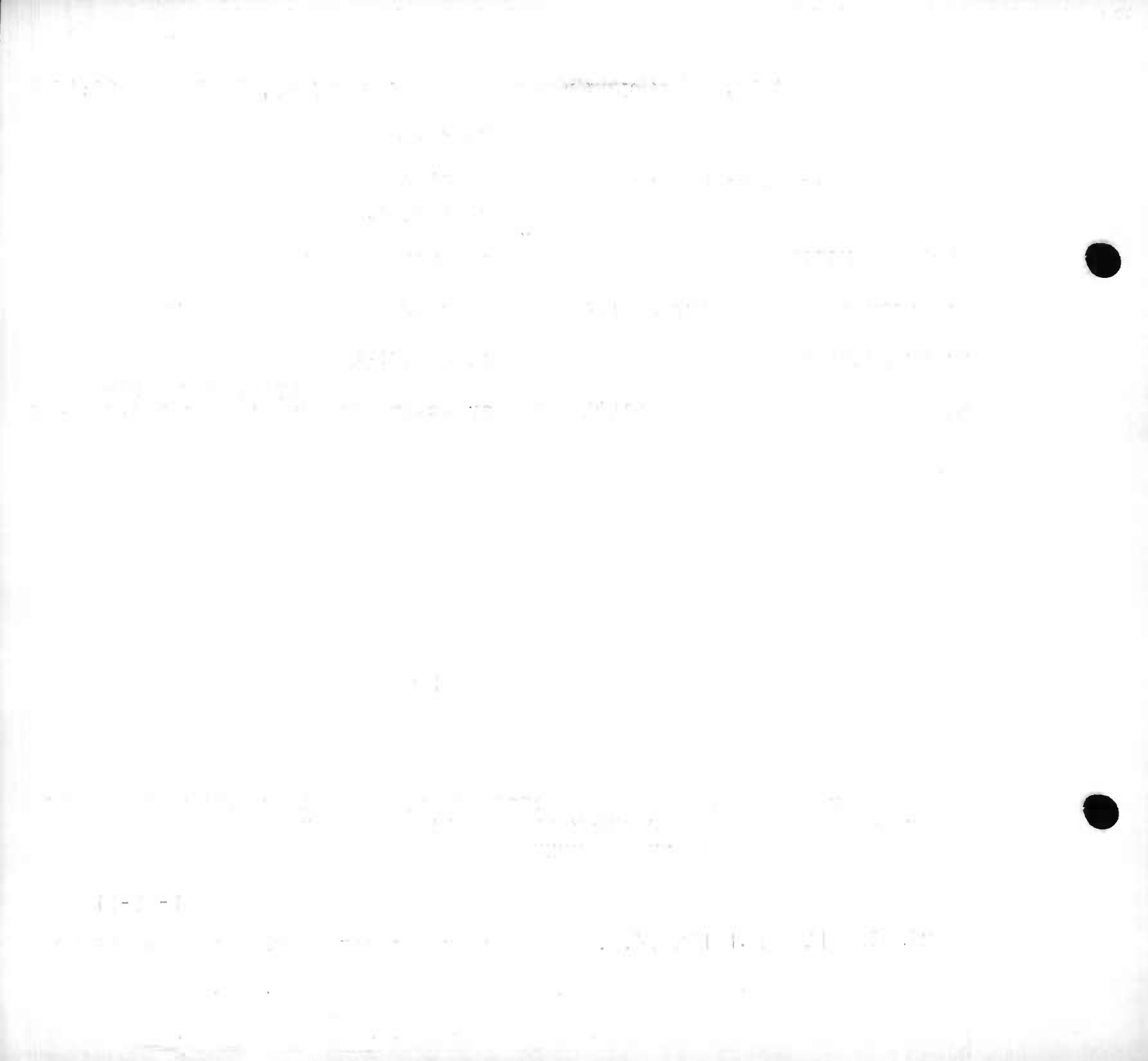
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

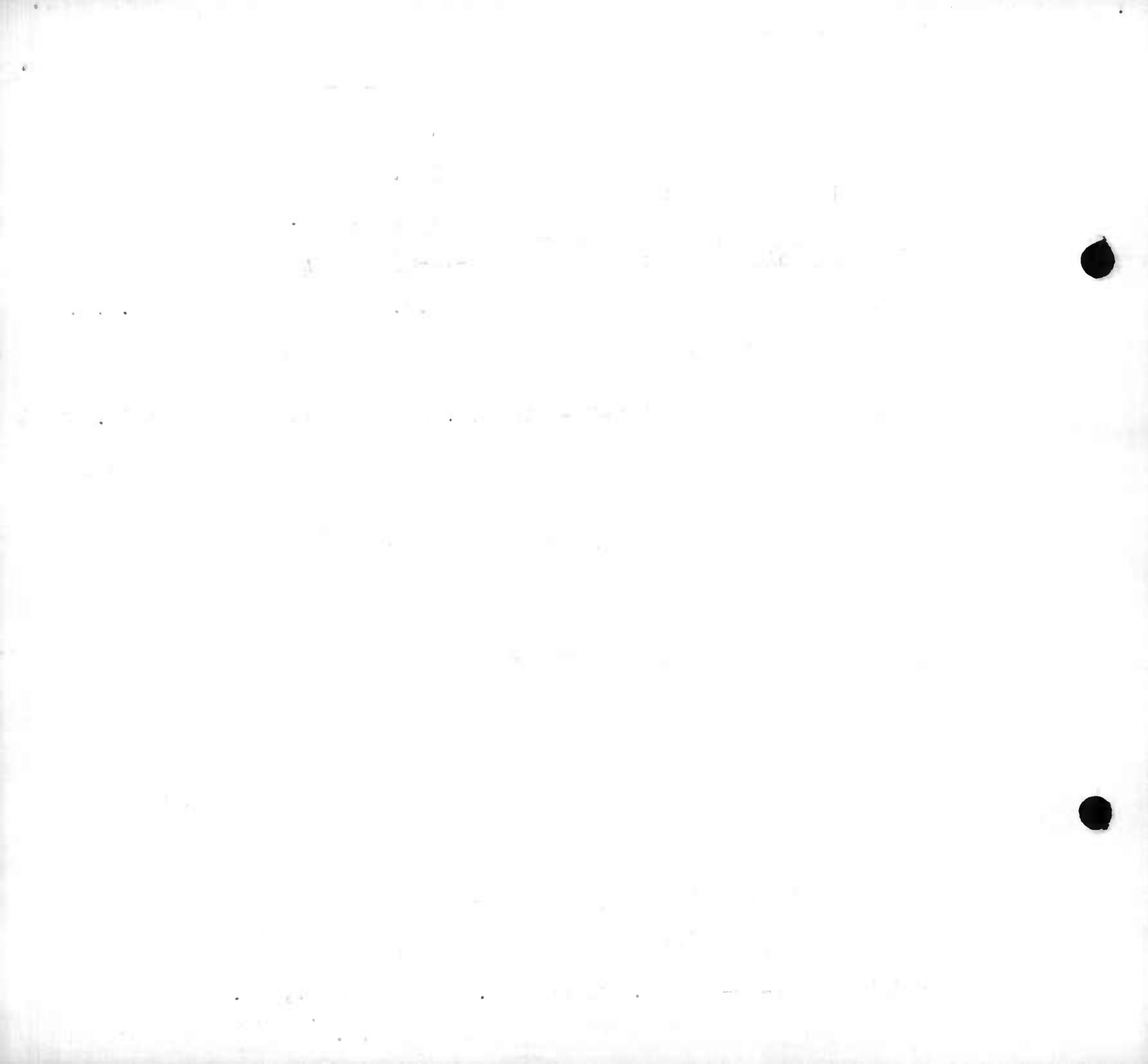
| | | | | | | | |
|---|------------------|---|------------------------------|---|---|--|--|
| F456 | | 71 0908 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0908 | |
| BIRTH NO. | | 71 0908 | | CERTIFICATE OF DEATH | | REG. NO. 71 0908 | |
| 1. NAME OF DECEASED (Type or Print) FULMORE, RONNIE CLIFTON | | | | 2. DATE AND HOUR OF DEATH JANUARY 27, 1971 10:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2047 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 55 S MONASTERY AVE | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/22/46 | 9. AGE (In years lost birthday) 24 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR | | 10B. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME MANZY FULMORE | | | | 14. MOTHER'S MAIDEN NAME IOLA MAGILL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO yes 2/15/66*1/24/68 | | 16. SOCIAL SECURITY NO. 214446822 | | 17. INFORMANT BALTIMORE MD 21229 ST AGNES RECORDS WILKENS & CATON AVES | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION Dec. 26, 1970 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Appendicitis 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location) (A) IMMEDIATE CAUSE Severe massive bilateral pneumonia; pleural effusion; Septicemia; suppurative abscess (B) DUE TO, OR AS A CONSEQUENCE OF: Ruptured appendicitis (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 26 19 70 to JANUARY 27 19 71 that (X) (we) last saw the deceased alive on JANUARY 27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 23A. SIGNATURE Hermenegildo N. Sidro 23B. DATE SIGNED Jan 27 1971 | |
| 23C. PHYSICIAN'S NAME (Type) HERMENEGILDO N. SIDRO, M.D. | | 23D. ADDRESS WILKENS & CATON AVES BALTO MD 21229 | | 23E. PHYSICIAN'S DEGREE DEGREE | | 23F. PHYSICIAN'S DEGREE DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-31-71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR V. Bailey Kelson F.H. 4348 Calhoun St. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

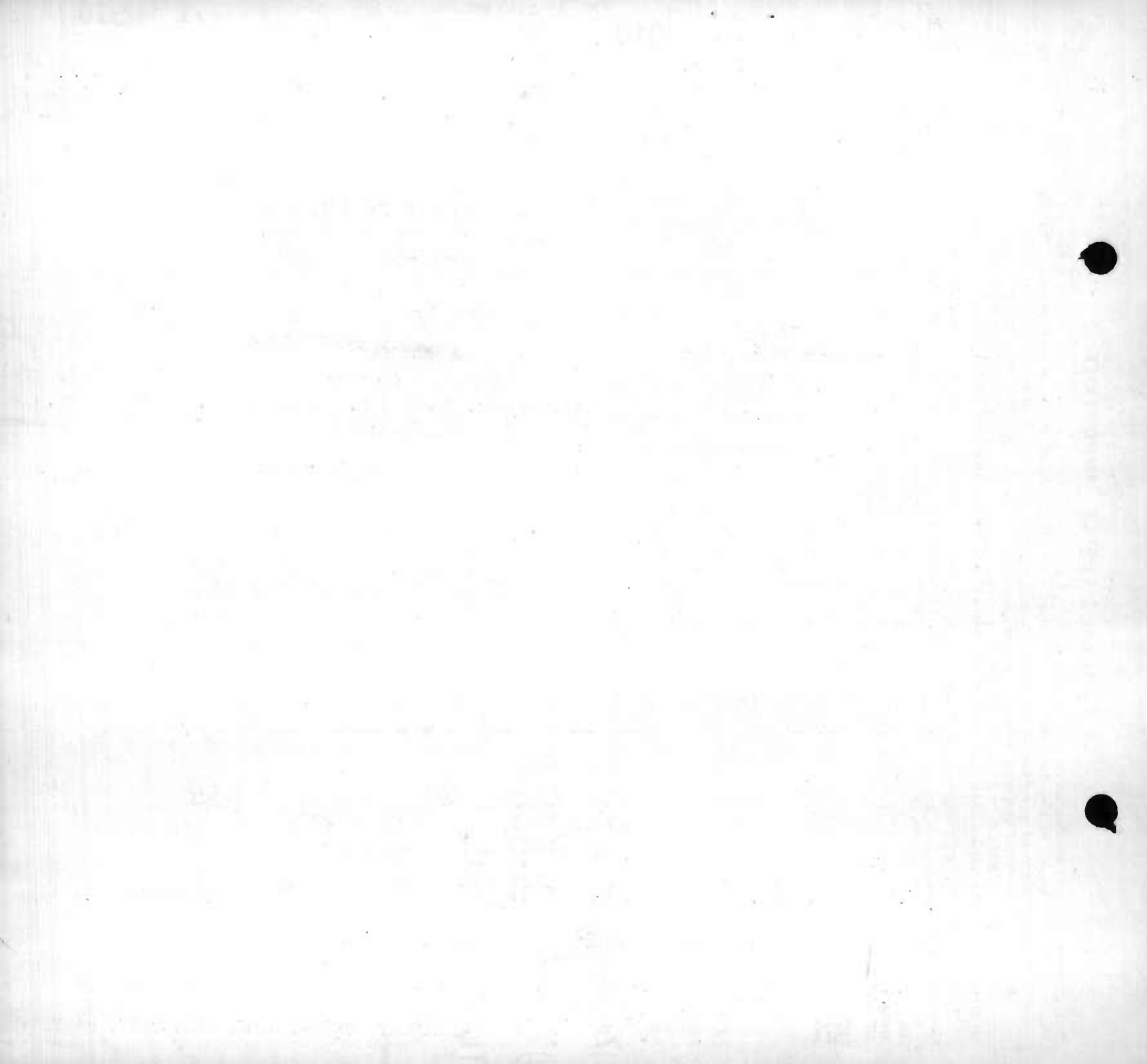
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0909 | | 71 0909 | |
|---|---------|--|---|---|------------------------------|--|--|
| BIRTH NO. | | | | 1-26-71 | | M. | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Anna Davis | | | | 1-26-71 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| 00 461 Walton Court | | | | Md. | | 1702 | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 461 Walton Ct. | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| F | Negroid | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 2-11-06 | 64 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| domestic | | | S.C. | | U.S.A. | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John Berkett | | | | Rose Capell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| no | | 220-24-2670 | | Geo. Davis | | 1615 Pentwood Rd. 21212 | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | Cerebral Thrombosis | | | |
| ANTECEDENT CAUSES | | | | (B) Anterior Ischemic Heart Disease | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | 2 1/2 | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-26-69 19 to 1-26-71 19 that (I) (we) last saw the deceased alive on 1-26-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| G. Franklin Phillips M.D. | | | | 1/28/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| G. Franklin Phillips M.D. | | | | 558 Mt. Vernon St. Balto. Md. 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 1-30-70 | | Mt. Auburn Cem. | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JAN 29 1971 | | Robert E. Fisher, M.D. | | V. Bailey | | 1348 Calhoun Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0910 | |
|---|--|---|--|--|--|
| K-152 | | 71 0910 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Edward Raymond Robinson, Jr.</i> | | 2. DATE AND HOUR OF DEATH <i>1/23/71 11:18 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>WICOMICO</i> | | 7200 | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>MARDELA SPRINGS</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>MALE</i> | | 6. RACE <i>WHITE</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <i>7-13-32</i> | | 9. AGE (In years last birthday) <i>38</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | 11. BIRTHPLACE (State or foreign country) <i>New York</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Edward RAYMOND ROBINSON</i> | | 14. MOTHER'S MAIDEN NAME <i>Annette MARGERY LAMPHIRE</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>220-32-7537</i> | | 17. INFORMANT (Father) <i>Mr. Raymond E. Robinson, Sr., Mardela, Md.</i> ADDRESS <i>Box 67</i> | |
| 18. <i>395.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Heart Failure</i> | | <i>7 days</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Aortic insufficiency</i> | | <i>7 days</i> | |
| | | (C) <i>Subacute bacterial insuff</i> | | <i>5 mo</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 21 1971</i> to <i>1/23 1971</i> , that (I) (we) last saw the deceased alive on <i>1/23 1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Michael Allen Moore MD</i> | | 23B. DATE SIGNED <i>January 23, 1971</i> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MICHAEL ALLEN MOORE</i> | | 23D. ADDRESS <i>Johns Hopkins</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/27/71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mardela Memorial Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Mardela, Wicomico, Maryland</i> | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1971</i> | | 25B. NAME OF REGISTRAR <i>John E. Taylor, MD</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND</i> | |



B-240

71 0911

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0911

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Anna L. Buckley | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1909 Eastern Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 26 71 5:20 p.m. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 203 | |
| 9. DATE OF BIRTH Sept. 14, 1893 | | 10. AGE (In years last birthday) 77 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH Azotemia and congestive heart failure <u>Pending</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: due to Arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/29/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/29/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | ADDRESS | |

Letter from M.E.'s office

2-2-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. [REDACTED] | |
|---|-------------------------|---|--|--|---|---|---|
| BIRTH NO. B-530 | | 71 0912 | | 71 0912 | | | |
| 1. NAME OF DECEASED (Type or Print) BANDY, MARY E. | | | | 2. DATE AND HOUR OF DEATH Jan. 27th - 71 8:25 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE U.S.A. B. COUNTY 301 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1213 Light St., Baltimore | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-14-90 | 9. AGE (in years last birthday) 81 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME 2 Robert Jenkins | | | 14. MOTHER'S MAIDEN NAME ? Rosa Davis | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | | 16. SOCIAL SECURITY NO. 217-54-2044-J1 | | 17. INFORMANT Harbor View Nursing Home 1213 Light St. Baltimore, Maryland 21230 | | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASEVD. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last CHF | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Surat S. [Signature] | | | | 23B. DATE SIGNED 1/27/71 | | 23C. PHYSICIAN'S NAME (Type) DEGREE | |
| 23D. ADDRESS DEGREE | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-30-1971 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. | | ADDRESS 1901-07 Eastern Ave. | |

11/18/77 adm. date 300 Mason Ct.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0913 | |
|--|--|---|--|--|---|
| J-552 71 0913 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Jackson Jennings | | 1-28-71 12:40 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Center | | | A. STATE Maryland | | |
| | | | B. COUNTY 2102 | | |
| | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1339 Ward St. | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-14-1905 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Hunter | | 14. MOTHER'S MAIDEN NAME Druid Seller | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 223-16-5545 | | 17. INFORMANT John Ingram ADDRESS 1339 Ward St. | |
| 18. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Terminal Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pseudo-tubercular Abscess (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C. V. Disease (C) Hypertension | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/27/71 to 1/28/71 and that (I) (we) last saw the deceased alive on 1/26/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph S. Belcher | | | | 23B. DATE SIGNED 1/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) Joseph S. Belcher | | 23D. ADDRESS 1115 N. Calver St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 2-1-71 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Charles A. Rice ADDRESS 661 W. Barre St. | |



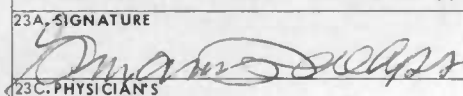
FUNERAL DIRECTOR: IMPORTANT

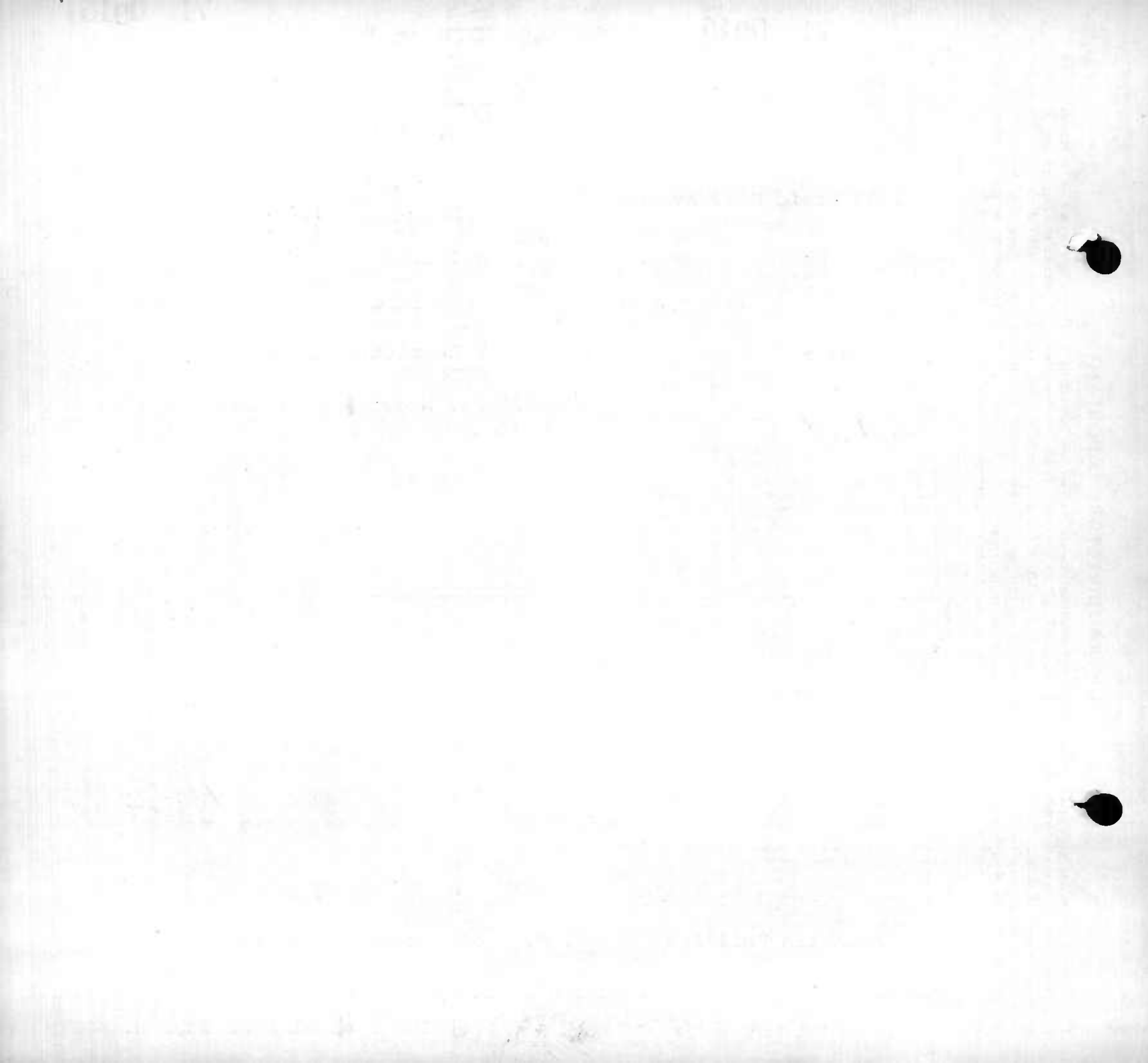
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|-------------------------|---|------------------------------------|---|---|
| 71 0914 | | 71 0914 | | 71 0914 | |
| 1. NAME OF DECEASED (Type or Print) <i>Leslie A. Bell</i> | | 2. DATE AND HOUR OF DEATH <i>Jan 26, 1971 8 45 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1506</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Luthan Hospital</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER <i>3711 Clifton Ave</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7-10-05</i> | 9. AGE (in years last birthday) <i>65</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Linotype Operator</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Newsprint</i> | | 11. BIRTHPLACE (State or foreign country) <i>Florida</i> | |
| 13. FATHER'S NAME <i>Alexander Bell</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna D. Henry</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>253-03-4346</i> | | 17. INFORMANT <i>Mr. William Culbreath</i> | |
| | | | | ADDRESS <i>3711 Clifton Ave</i> | |
| 18. <i>436.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>CEREBRO-VASCULAR ACCIDENT</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/26/1971</i> to <i>1/26/1971</i> that (I) (we) last saw the deceased alive on <i>1/26/1971</i> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Azad Cader</i> | | MD DEGREE <i>AZAD. CADER</i> | | 23B. DATE SIGNED <i>1/26/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1-30-1971</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial Park</i> | |
| 24D. LOCATION <i>Baltimore Co. Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1971</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

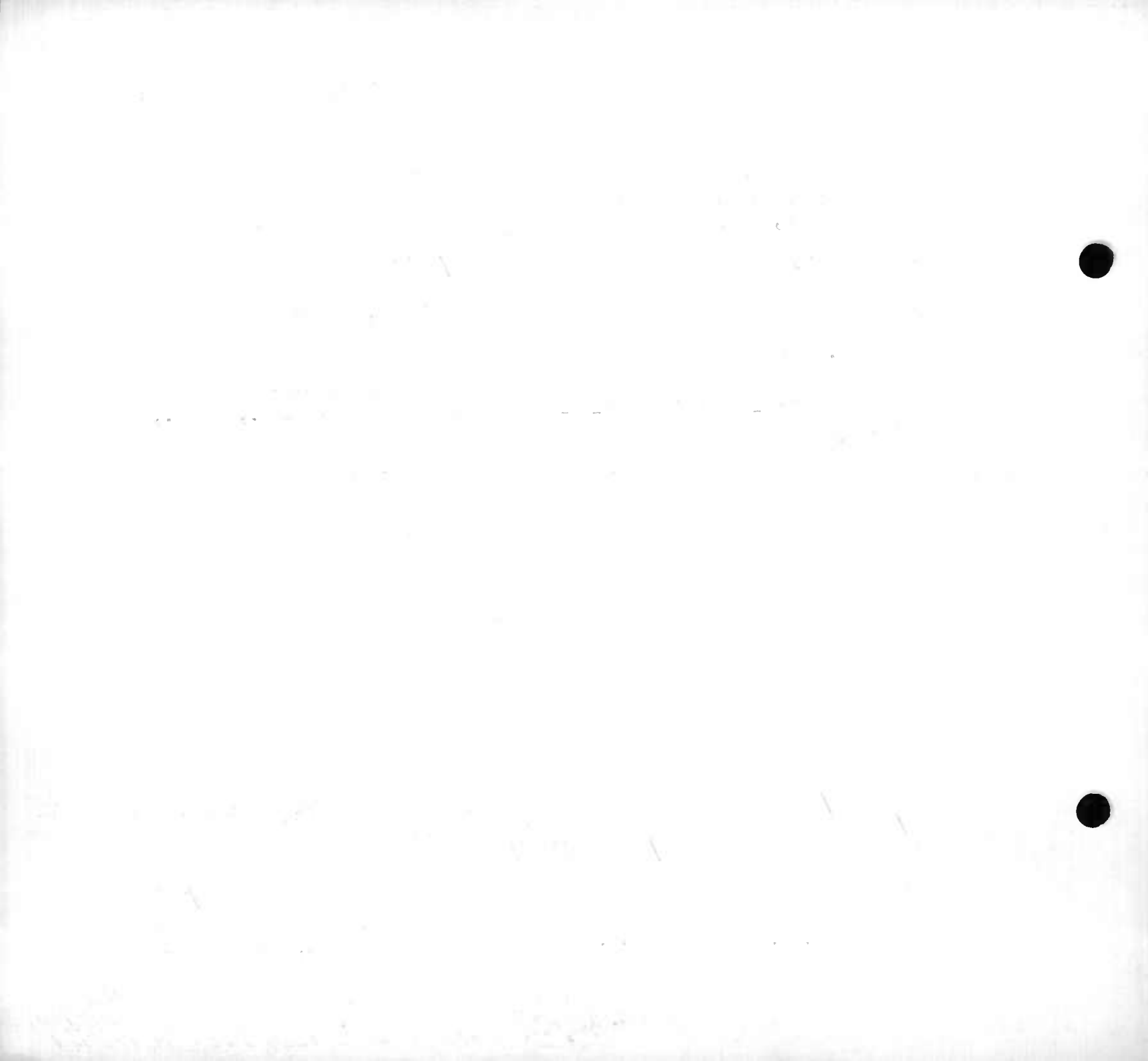
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0915 | |
|---|--|---|--|--|--|
| 71 0915 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Henrietta Johnson Brown | | 2. DATE AND HOUR OF DEATH January 27, 1971 8:05 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1303 Druid Hill Avenue | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female | | 6. RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid | | 10B. KIND OF BUSINESS OR INDUSTRY Stadium | | 8. DATE OF BIRTH 9-2-1893 9. AGE (In years last birthday) 77 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Lloyd Brown | | 14. MOTHER'S MAIDEN NAME Henrietta Johnson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-30-9226 | | 17. INFORMANT ADDRESS Mrs. Maggie Pitts Derricks 1303 Druid Hill Ave | |
| 18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic Heart Disease | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Degeneration | | (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/28 19 70 to 1/27/71 19 71 , that (I) (we) last saw the deceased alive on 1/27/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | DEGREE | | 23B. DATE SIGNED 1/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips | | 23D. ADDRESS M. D. 558 McMechan Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-1971 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION Baltimore | | 24E. STATE Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS OUTTER FUNERAL HOME 3035 W. NORTH AVENUE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

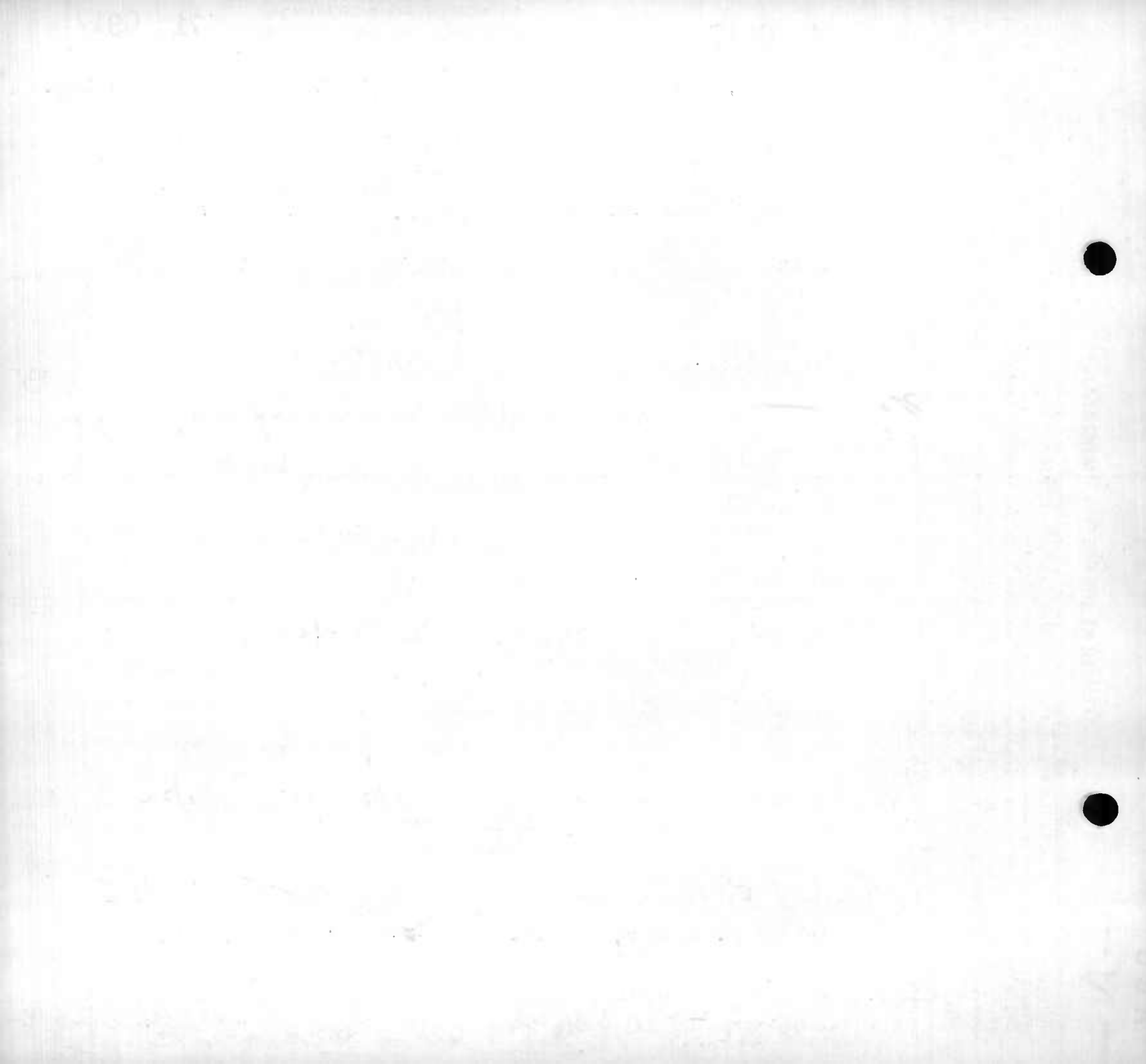
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0916 | |
|---|--|---|--|---|--|
| 71 0916 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) DICUS, JOHN WALTER | | 2. DATE AND HOUR OF DEATH 1/26/71 18:45 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | A. STATE Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 1937 Lemmon Street | | |
| 5. SEX Male | | | 6. RACE White | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 8/30/23 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Driver | | | 9. AGE (In years last birthday) 47 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | |
| 13. FATHER'S NAME Walter L. Dicus | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 8/15/42 - 12/20/46 | | | 16. SOCIAL SECURITY NO. 217-14-2326 | | |
| 17. INFORMANT VA Hospital Records | | | ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218 | | |
| 18. 5832 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Renal Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Glomerulonephritis DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | Probable intracerebral hemorrhage | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 23rd 19 71 to January 26th 19 71 that (I) (we) last saw the deceased alive on January 26th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm D Hakkarinen MD | | | | 23B. DATE SIGNED 1/26/71 | |
| 23C. PHYSICIAN'S NAME (Type) WM. D. HAKKARINEN M.D. | | | | 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1/30/71 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | |
| 24D. LOCATION Balto. | | 24E. STATE Md. | | 24F. CITY, TOWN, OR COUNTY Balto. | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR George L. Schwab, Inc. | | 25C. FUNERAL DIRECTOR 2101 Fred. Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0917 | |
|---|---|--|---|---|---|
| BIRTH NO. 71 0917 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CERINO, Vincent | | | 2. DATE AND HOUR OF DEATH 1/26/71 8:20 a. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 702 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 501 N. Belnord Avenue | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9/11/00 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy mfg. | | 10B. KIND OF BUSINESS OR INDUSTRY self-employed | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 13. FATHER'S NAME Augustine Cerino | | | 14. MOTHER'S MAIDEN NAME Sorbetli (?) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-01-4009 | | 17. INFORMANT Mrs. Mary Gurney | |
| 18. 519.341162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Coronary artery heart (B) Chronic obs. lung disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mi 20 y | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Squamous Cell Ca of Lung | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/12 1971 to 1/26 1971, and that (I) (we) last saw the deceased alive on 1/26 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael A. Merser | | | | 23B. DATE SIGNED 1/26 | |
| 23C. PHYSICIAN'S NAME (Type) Michael A. Merser, M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | |
| 25B. NAME OF REGISTRAR E. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR J. J. Schwab, Jr. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

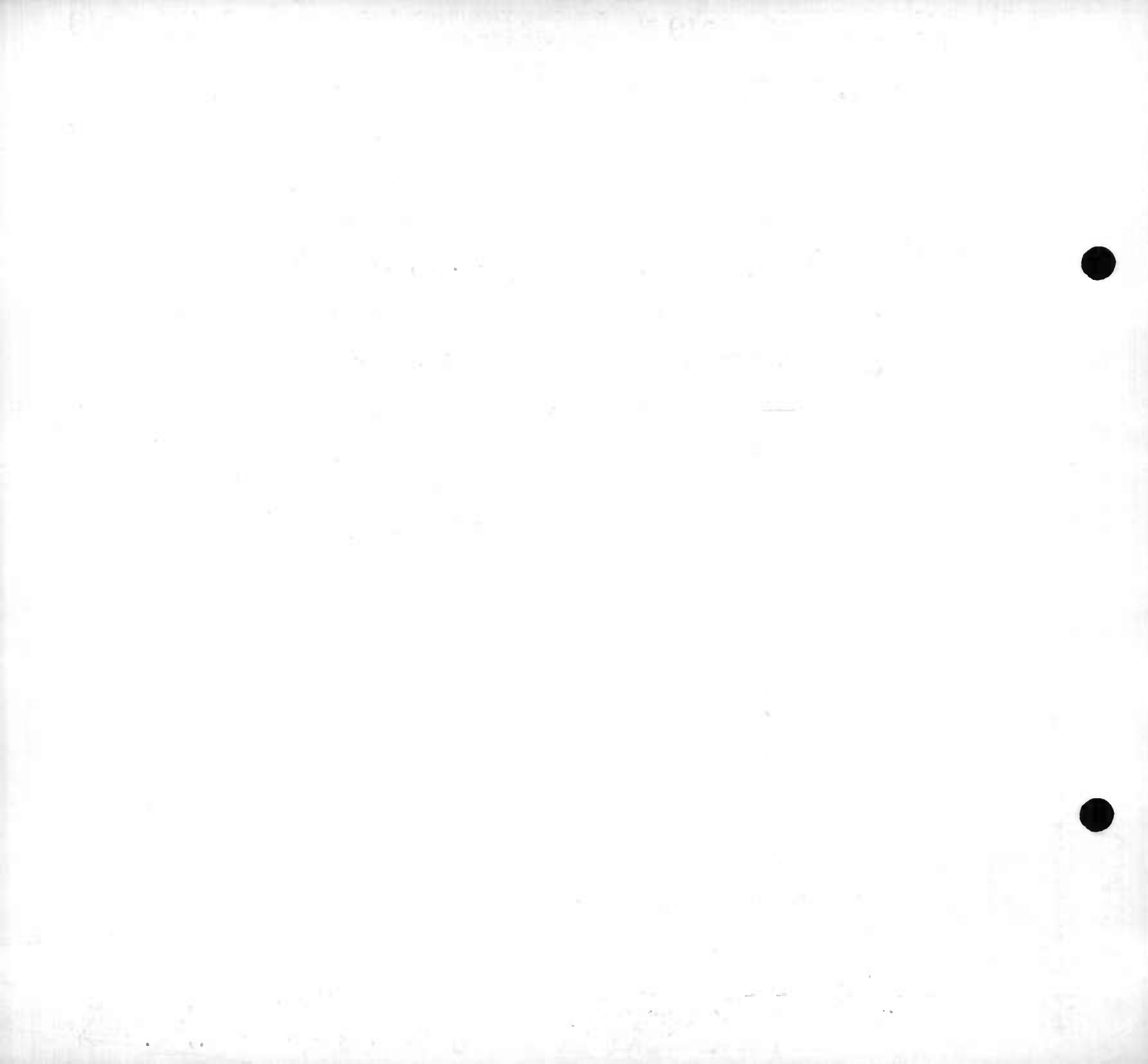
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0918 | |
|--|---------|--|---|--|---|
| <div style="font-size: 1.5em; font-weight: bold;">W-630</div> <div style="font-size: 1.5em; font-weight: bold;">71 0918</div> | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Margaret Ward | | 1-25-71 9:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | A. STATE | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | B. COUNTY | | |
| 90 Bolton Hill Nursing & Convalescent Center | | | Maryland | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 683 Pierce Street | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. Months Days |
| Female | Negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 5-3-1903 | 67 | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic | | | | North Carolina | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| | | | USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 217-64-5159 | | Mrs Mary Bailey, 2871 W Lanvale St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | Sudden | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Cardiac Arrest | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | Carcinoma Cervix - Bladder + Uterus | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | A.S.C. V. Disease | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/23 to 1/25/71 that (I) (we) last saw the deceased alive on 1/23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Joseph S. Blum, M.D. | | | 1/25/71 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| JOSEPH S. BLUM, M.D. | | | 1115 N. Calvert St | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/29/71 | | Mt C lvery Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JAN 29 1971 | | Robert E. Fisher, Jr. | | Adolphus Halstead 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

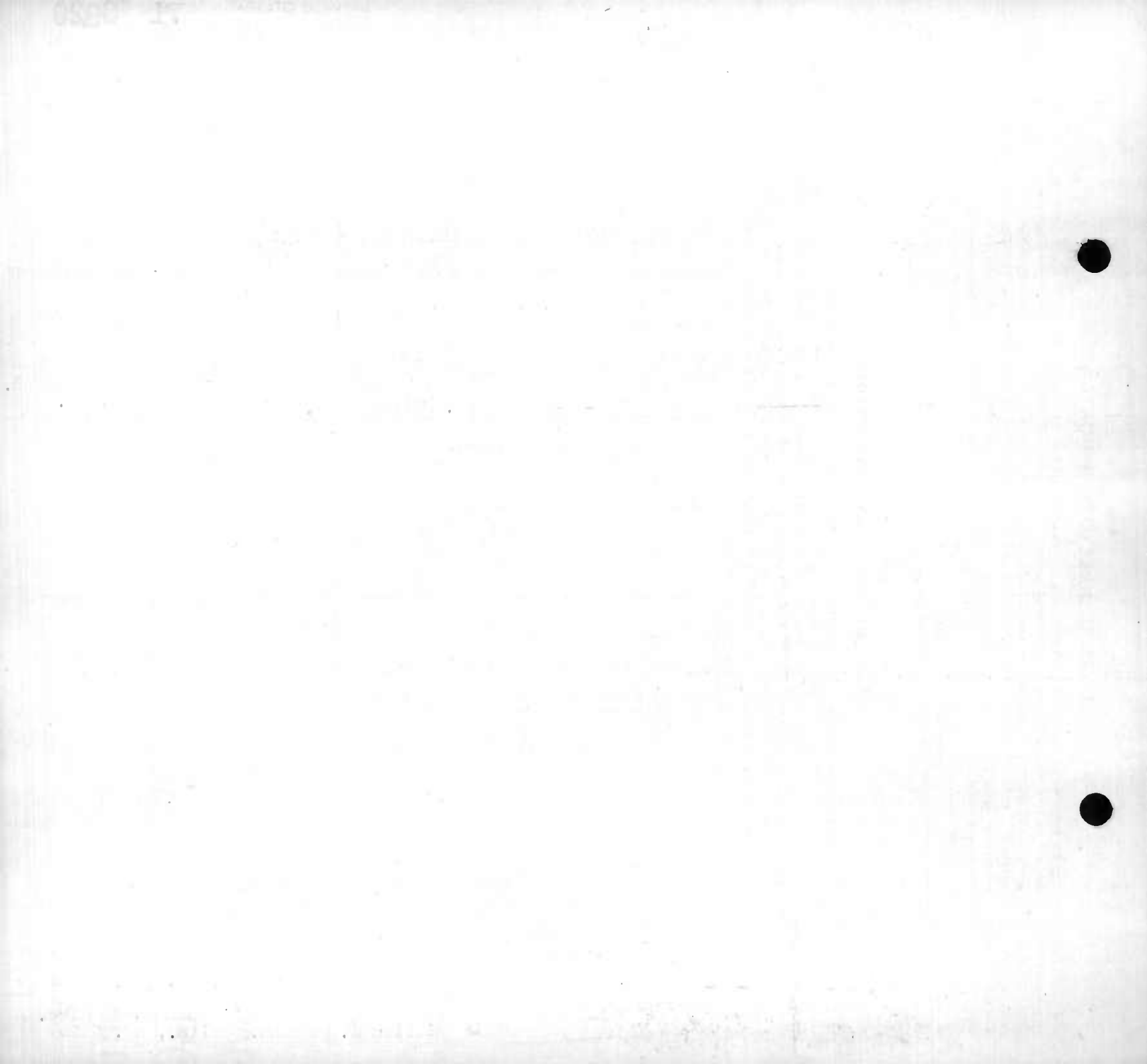
| | | | | | |
|---|---------------------|---|---|--|---|
| T-620 71 0919 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0919 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Tracey, Tracey, ESTHER E | | | 2. DATE AND HOUR OF DEATH January 26, 1971 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | B. COUNTY 2749 | | |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1527 KENTRIDGE RD | | |
| 5. SEX Female | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 10, 1898 | 9. AGE (in years last birthday) 72 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William Wm Duncan | | | 14. MOTHER'S MAIDEN NAME Ida Duncan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219 18 0569 | 17. INFORMANT MRS. SHIRLEY COCHRAN | | |
| | | | ADDRESS BENTLEY SPRING MARYLAND | | |
| 18. 410.91 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Anterior Lat Myocardial Infarction | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic Shock | | | |
| | | (C) / | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 1.26.71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) 1.26.71 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1.26.71 to 1.26.71 19 that (I) (we) last saw the deceased alive on 1.26.71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Mahmood Ali Khan | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) Mahmood Ali Khan | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-29-71 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | |
| 24D. LOCATION Baltimore County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | | |
| 25B. NAME OF REGISTRAR William E. Johnson | | 25C. FUNERAL DIRECTOR 8521 Loch Raven Blvd Balto., Md. 21204 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0920 | |
|---|------------|--|----------------------------|---|--|
| BIRTH NO. H-546 | | 71 0920 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Hainmiller Herbert | | 2. DATE AND HOUR OF DEATH 1/28/71 12:30 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1102 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 12 West BIDDLE ST. | | | |
| 5. SEX M | 6. RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/1/93 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer | | 10B. KIND OF BUSINESS OR INDUSTRY Retired Drug | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Henry Hainmiller | | 14. MOTHER'S MAIDEN NAME Isabelle Hoffman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-07-6670 | | 17. INFORMANT Mrs. Elizabeth H. Smith | |
| | | | | ADDRESS Box 343 Glen Arm Rd. Baltimore, Md. | |
| 18. 189.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) Debilitation 2° to Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) Coronary Artery Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1/18/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Hypertension | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/21 1970 to 1/28 1971, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. McLaughlin | | DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) M. McLaughlin | | 23D. ADDRESS J. H. N. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-30-71 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR William E. Johnson | | 25C. FUNERAL DIRECTOR 8521 Loch Raven Blvd. Balto., Md. 21204 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

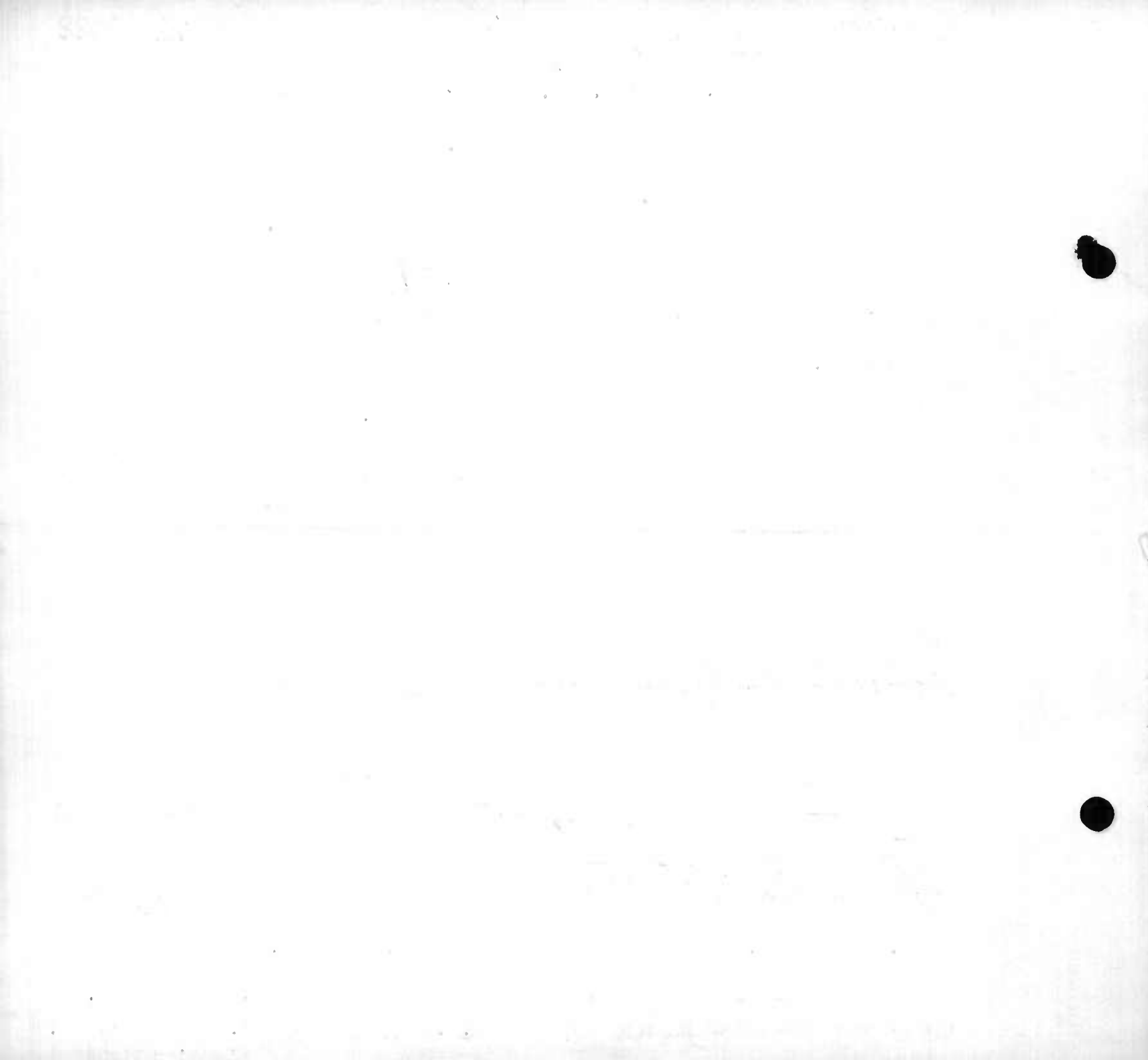
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|---|-------------------------|---|------------------------------------|---|
| Baltimore City Health Department | | 71 0921 CERTIFICATE OF DEATH | | REG. NO. 71 0921 |
| BIRTH NO. L-520 | | | | |
| 1. NAME OF DECEASED (Type or Print) Lawrence J. Lyng, Sr. | | 2. DATE AND HOUR OF DEATH 1-27-71 10:50 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc. | | A. STATE Maryland B. COUNTY Baltimore | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | E. STREET AND NUMBER 6704 Tweedbrook Road #21212 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/19/04 | 9. AGE (In years last birthday) 66 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | 10B. KIND OF BUSINESS OR INDUSTRY Bowling Lanes | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Thomas Lyng | | |
| 14. MOTHER'S MAIDEN NAME Mary Mc Grath | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 212-05-3726-4 | | 17. INFORMANT Angela Lyng ADDRESS 6704 Tweedbrook Road Baltimore, Maryland 21212 | | |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 162.1 I | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Re-sided Pl. Effusion | | | | |
| (B) Predisposing Cause of Lung | | | | |
| (C) | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 1/15/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED for diagnostic | | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 1/12 19 71 to 1/27 19 71 that (I) (we) last saw the deceased alive on 1/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Pratima Bose MD | | 23B. DATE SIGNED 1/27/71 | | 23C. PHYSICIAN'S NAME (Type) PRATIMA BOSE MD |
| 23D. ADDRESS Mercy Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 1-30-71 | | 24C. NAME OF CEMETERY OR CREMATORY Moveland Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR William B. Johnson ADDRESS 8521 Loch Raven Blvd. Balt., Md. 21204 |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0922</u> |
|--|---------------------|---|------------------------------------|---|
| BIRTH NO. <u>S-132</u> | | 71 0922 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED (Type or Print) <u>Richard B. Spencer, Jr.</u> | | 2. DATE AND HOUR OF DEATH <u>1-28-71</u> <u>12²⁰ P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>619 Tunbridge Rd.</u> | | A. STATE <u>Md.</u> B. COUNTY <u>2778</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER <u>619 Tunbridge Rd.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-16-17</u> | 9. AGE (In years last birthday) <u>53</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u> |
| 13. FATHER'S NAME <u>Richard B. Spencer</u> | | 14. MOTHER'S MAIDEN NAME <u>Ethel Burgert</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-14-4833</u> | | 17. INFORMANT <u>Julian M. Spencer</u> |
| | | | | ADDRESS <u>Same</u> |
| 18. <u>150 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of esophagus with metastases</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of esophagus with metastases</u> | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION <u>Jan 1970</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of esophagus</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/13/64</u> 19 <u>71</u> to <u>1/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>William F. Renner</u> | | | | 23B. DATE SIGNED <u>1/29/71</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. William F. Renner</u> | | | | 23D. ADDRESS <u>3222 St. Paul St.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>2-1-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crematory</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1971</u> | | 25B. NAME OF REGISTRAR <u>Chas E. Jenkins</u> | | 25C. FUNERAL DIRECTOR <u>HOW. Jenkins Sons Co.</u> |
| | | | | ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u> |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 0923 | |
|--|-------------------------|---|--|---|--|---|---|
| BIRTH NO. B-240 | | | | 71 0923 | | | |
| 1. NAME OF DECEASED (Type or Print) Edna Boswell | | | | 2. DATE AND HOUR OF DEATH 1-26-71 2:45 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Stella Maris Hospice | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-10-89 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIME-KEEPER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James Trotton | | | 14. MOTHER'S MAIDEN NAME Jane W. Gatechair | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | 16. SOCIAL SECURITY NO. 212-09-3199-A | | 17. INFORMANT STELLA MARIS HOSPICE | | ADDRESS DULANEY VALLEY Rd. Towson, Md. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) MASSIVE Pulmonary Emboli few hours? ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: bilateral (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Vascular Heart Disease. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) (Yes) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Pulmonary Emboli | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-26-71 to 1-26-71 that (I) (we) last saw the deceased alive on 1-26-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Arthur Songer | | | | M.D. DEGREE <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1-27-71 | |
| 23C. PHYSICIAN'S NAME (Type) SUTIN SONGER | | 23D. ADDRESS MERCY HOSPITAL BALTIMORE MD. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-29-71 | | 24C. NAME of CEMETERY or CREMATORY MORELAND MEMORIAL | | 24D. LOCATION (City, town, or county) (State) BALTO. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR W. E. SUTIN | | 25C. FUNERAL DIRECTOR W. COOK BROOKS | | ADDRESS 1050 BKK Rd. Towson, Md. | |

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71 0924 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0924

BIRTH NO.

| | | | | |
|--|-------------------------|---|--|--|
| 1. NAME OF DECEASED (Type or Print) WILLIAM JAMES DUNN | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year January 23, 1971 | | Hour 5:45 P.M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year January 23, 1971 | | Hour 5:45 P.M. |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Washington |
| 9. DATE OF BIRTH 3/6/17 | | 10. AGE (In years lost birthday) 53 | E. STREET AND NUMBER 4201 Weldon Drive, S.E. | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James Dunn |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor | | 14B. KIND OF BUSINESS OR INDUSTRY Carpet Industry | | 15. MOTHER'S MAIDEN NAME Ann Burnett |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 179-12-2432 | | 18. INFORMANT Hortense Ann Dunn-Wife Same as above |
| 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 20A. DATE OF OPERATION 1/23/71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1/23/71 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 24, 1971 EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/27/71 | | 24C. NAME of CEMETERY or CREMATORY Resurrection Cemetery |
| 24D. LOCATION (City, town, or county) (State) Clinton, Maryland 20735 | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | |
| 25B. NAME OF REGISTRAR Robert E. Wilhelm | | 25C. FUNERAL DIRECTOR Robt. E. Funerall Home | | |
| 25D. ADDRESS 4308 Suitland Rd., Suitland, Md. | | | | |

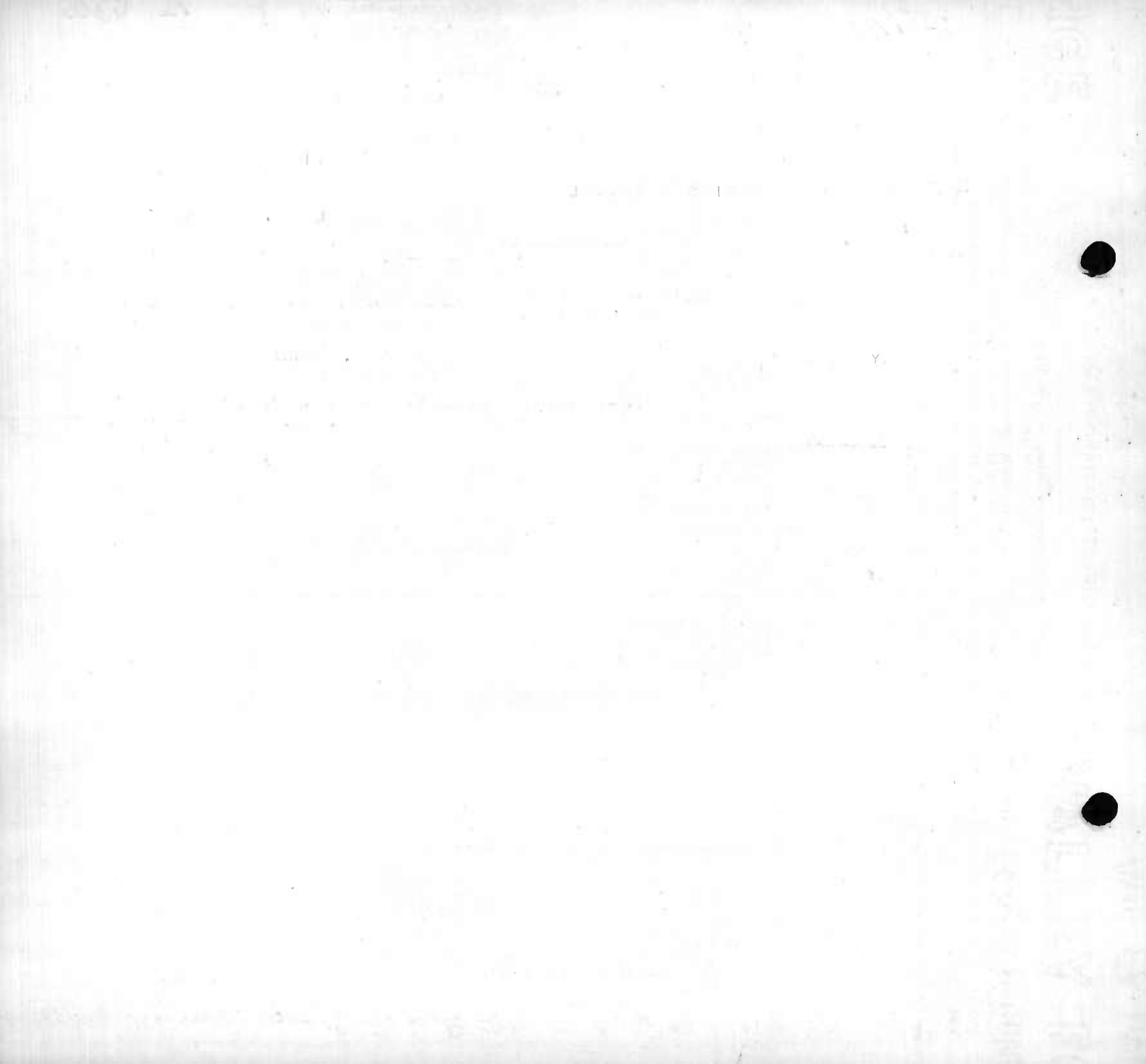
ACADEMIC RECORD

1/8/71 2003 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

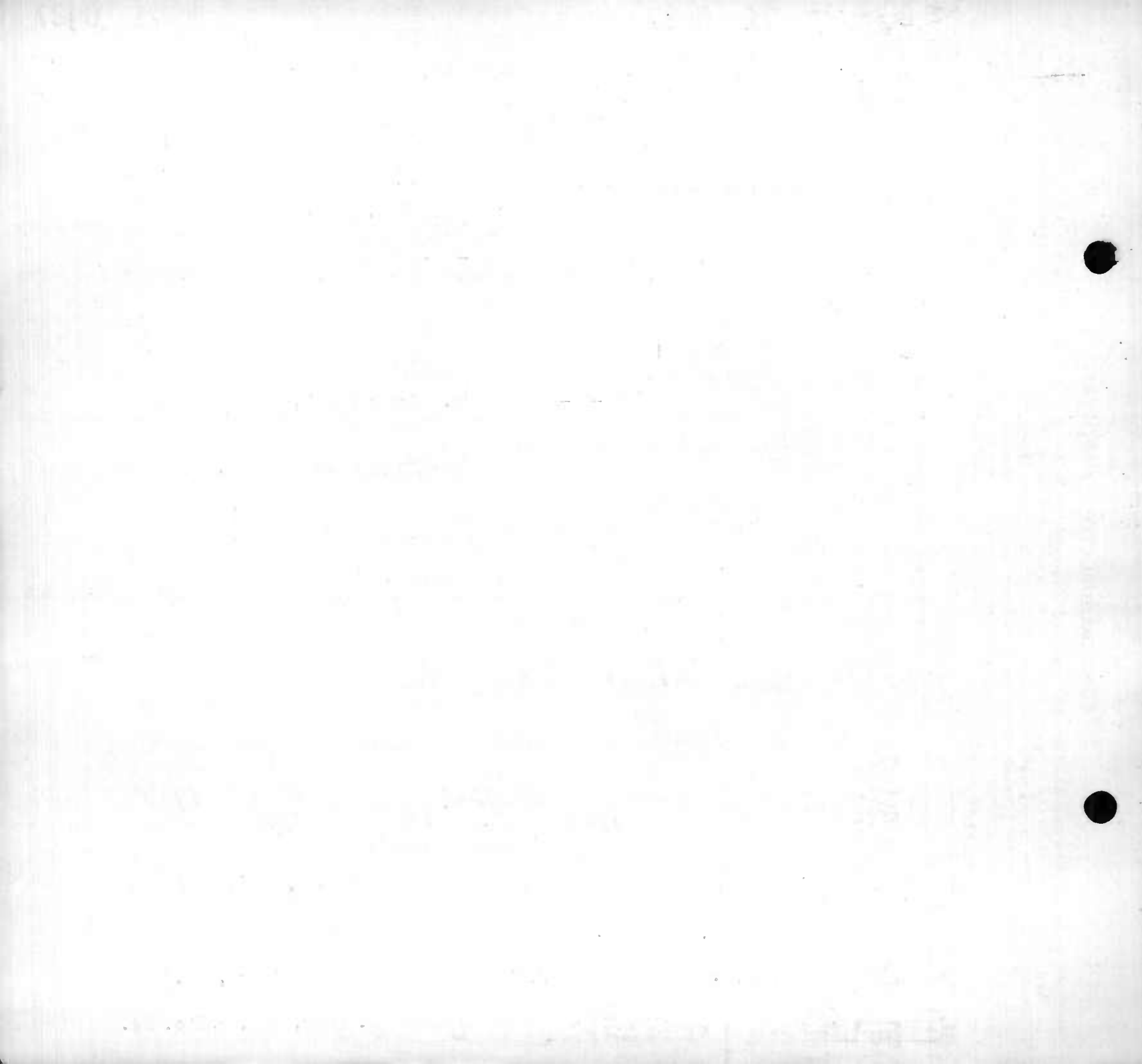
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|--|--|---|---|--|
| G-610 | | 71 0926 | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Elizabeth Greb</i> | | 2. DATE AND HOUR OF DEATH <i>1-29-71</i> | | 8-15 a. m. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 THE JOHNS HOPKINS HOSPITAL</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2778 YARNALL ROAD</i> <i>2778 YARNALL RD.</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9-26-36</i> | 9. AGE (In years last birthday) <i>34</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>I B M Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Md Blue Cross-Blue Shield</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>HENRY GREB</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>EMMA E. HAHN</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | |
| 16. SOCIAL SECURITY NO. <i>213-34-4272</i> | | 17. INFORMANT <i>Margaret M Greb (Sister)</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Arrhythmia</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Rheumatic Heart Disease</i> | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 21. MEDICAL CERTIFICATION | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 21A. DATE OF OPERATION <i>2</i> | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21C. AUTOPSY? (Yes or No) <i>Yes</i> | 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i> | |
| 21E. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21F. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21H. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21I. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21J. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-26</i> 19 <i>71</i> to <i>1-29</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>1-29</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <i>did</i> (did not) view the body after death. | | | | |
| 23A. SIGNATURE <i>Larry Kvols, MD</i> | | 23B. DATE SIGNED <i>1-29-71</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>LARRY KVOLS</i> | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>Mon Feb 1 71</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cem.</i> | 24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1971</i> | | 25B. NAME OF REGISTRAR <i>Charles Evans</i> | | |
| 25C. FUNERAL DIRECTOR <i>CURTIS E. EVANS</i> | | 25D. ADDRESS <i>1400 S CHARLES ST. MD 21230</i> | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0927 | |
|---|-------------------------|---|---|--|--|
| S-315 71 0927 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Blanche Stephenson</i> | | (BLANCHE STEPHENSON) | | 2. DATE AND HOUR OF DEATH <i>1/27/71 9:30 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2407 AILSA AVENUE <i>2733</i> | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-28-06 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Poland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME JOHN SZABLOWSKI | | |
| 14. MOTHER'S MAIDEN NAME PAULINE REKRUT | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 218-12-2566 | | | 17. INFORMANT ADDRESS Mrs. Mary Keydash, 5522 Sefton Avenue | | |
| 18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ventricular Fibrillation Immediate</i> (B) <i>Severe Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Severe ASCVD</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>1/27/71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cardiac Catheterization C.A.P.</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>1/26</i> 19 <i>71</i> to <i>1/27</i> 19 <i>71</i> , that (1) (we) last saw the deceased alive on <i>1/27</i> 19 <i>71</i> and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Richard L. Taw Jr. MD</i> | | | 23B. DATE SIGNED <i>1/27/71</i> | | 23C. PHYSICIAN'S NAME (Type) RICHARD L. TAW, JR. |
| 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 2/1/71. | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor MD</i> | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

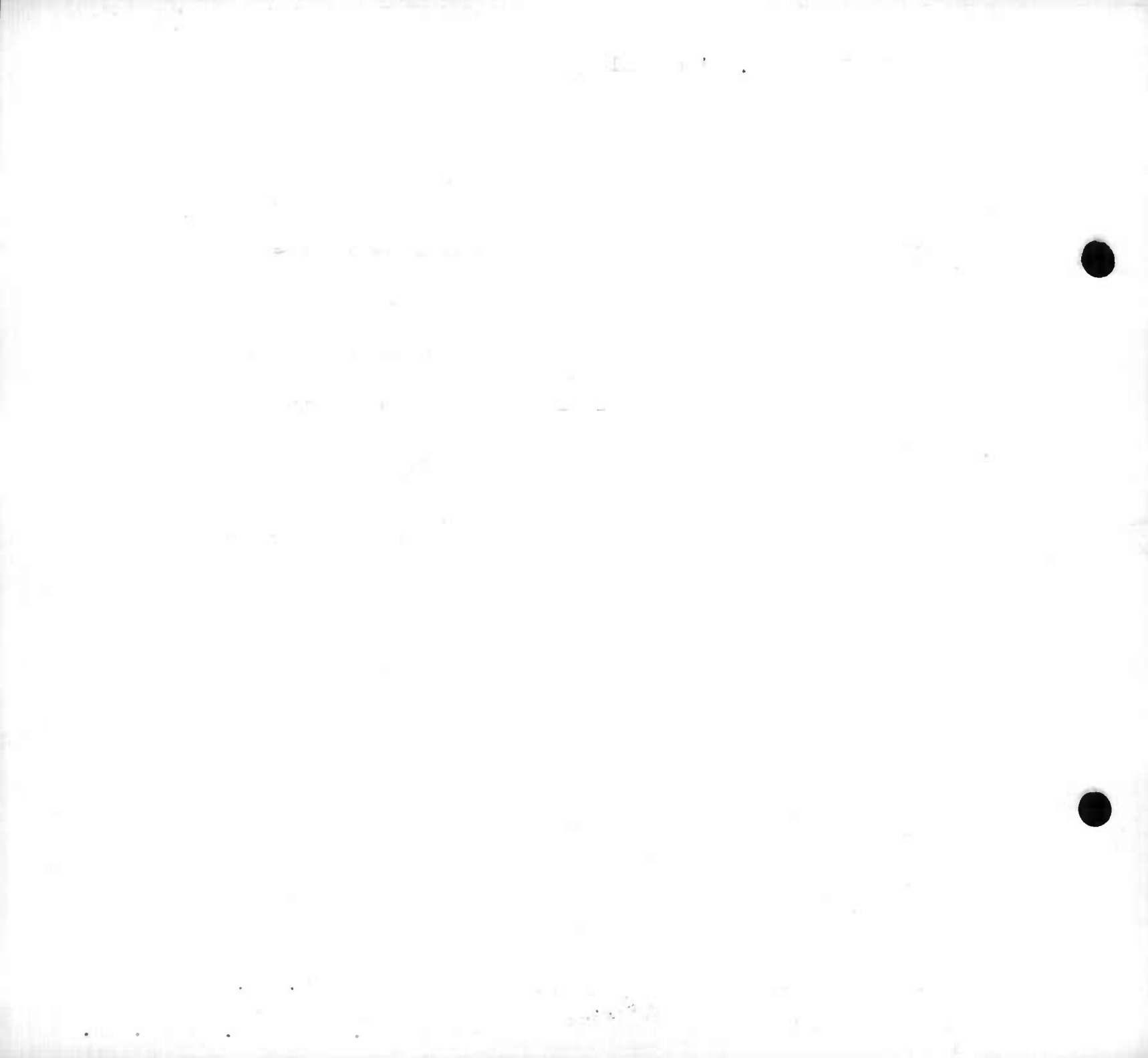
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0928 | |
|--|--------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> S-660 71 0928 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. XXXXXXXXXXXX | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| XXXXXXXXXXXX SCHERER, Edward | | | 4 PM 1/20/71 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | | A. STATE Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN Baltimore | | |
| | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 6005 Eurith Avenue | | |
| 5. SEX m | 6. RACE w | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/13/09 | 9. AGE (In years lost birthday) 61 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Umbrella Mfr. | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME August Scherer | | | 14. MOTHER'S MAIDEN NAME Theresa ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-10-2626 | 17. INFORMANT Mrs. Josephine Scherer | | |
| | | | ADDRESS (Same) | | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex;"> <div style="flex: 1;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Adenocarcinoma of Lung</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25 19 71 to 1/27 19 71, that (I) (we) last saw the deceased alive on 1/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>John M. Amatrucci MD</i> | | | | 23B. DATE SIGNED 1/27/71 | |
| 23C. PHYSICIAN'S NAME (Type) John M. Amatrucci MD | | | | 23D. ADDRESS 601 N. Broadway, Baltimore MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/71. | | 24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, MD. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | |
| | | | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0929</u> |
|--|--|--|--|---|
| BIRTH NO. <u>0-354 71 0929</u> | | 1. NAME OF DECEASED <u>William J. O'Donnell</u> | | |
| 2. DATE AND HOUR OF DEATH <u>1/27/71 11:035 A.M.</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Union Memorial Hospital</u> | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>905</u> | | 5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| E. STREET AND NUMBER <u>1118 Homestead Ave</u> | | 8. DATE OF BIRTH <u>6-9-47</u> 9. AGE (in years last birthday) <u>23</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA American</u> | | 13. FATHER'S NAME <u>Thomas J. O'Donnell</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Thelma Gardner</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>yes</u> | | |
| 16. SOCIAL SECURITY NO. <u>201-36-8976</u> | | 17. INFORMANT <u>Henry O'Donnell</u> ADDRESS <u>same</u> | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic Carcinoma</u> <u>Primary testicular carcinoma</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-21-71</u> 19 <u>71</u> to <u>1-27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1-27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>I. Cheikh</u> | | 23B. DATE SIGNED <u>1-27-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ISSAM E. CHEIKH</u> |
| 23D. ADDRESS <u>Union Memorial Hospital</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>1/30/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Kelly</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> ADDRESS <u>Balto. MD.</u> |



M-250

71 0930

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0930

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ANGELO MAZZONE | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour Month Day Year Hour 1 28 1971 5:25 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 28 1971 5:25 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 2706 | |
| 9. DATE OF BIRTH April 9, 1911. | | 10. AGE (in years lost birthday) 59 | |
| 11. BIRTHPLACE (State or foreign country) Vermont | | 12. CITIZEN OF USA | |
| 13. FATHER'S NAME Nicodemus Mazzone | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Technician--Johns Hopkins Univ. | |
| 15. MOTHER'S MAIDEN NAME Adelina Comolli | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 009-09-4238 | | 18. INFORMANT Mrs. Mary S. Leavitt | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-29-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71. | |
| 24C. NAME of CEMETERY or CREMATORY Lake View Memorial Cem. | | 24D. LOCATION (City, town, or county) (State) Eldersburg, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214 | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25D. ADDRESS | |

1930 IN

6000 4

RAILROADS
NORTH CAROLINA
1930

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-----------------------------|---|--|--|--|--|--|
| G-246 | | 71 0931 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0931 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) JOSEPH XXXXXX ANTHONY GAGLIARDI | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH January 28, 1971 1:00 A.M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2744 | | C. CITY OR TOWN Baltimore | |
| 3202 Hamilton Avenue | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 3202 Hamilton Ave, Balto, Md. | |
| 5. SEX male | 6. RACE caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-28-92 | | 9. AGE (in years last birthday) 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stonemason, retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John L. Gagliardi | | | | 14. MOTHER'S MAIDEN NAME Maria XXXX Jones Adelaide Gagliardi | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I | | 16. SOCIAL SECURITY NO. 218-01-3102 | | 17. INFORMANT Mrs. Lillian M. Gagliardi | | ADDRESS (Same) | |
| 18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebrothrombosis Left Middle Cerebral 70 hrs DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerosis & CV disease DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 23 1945 to January 28 1971 and that (I) (we) last saw the deceased alive on January 27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H.V. Harbold M.D. | | | | 23B. DATE SIGNED Jan. 28, 1971 | | 23C. PHYSICIAN'S NAME (Type) DR. HAROLD V. HARBOLD | |
| 23D. ADDRESS 4706 Harford Rd, Balto, Md. | | 23E. DEGREE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71. | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Ruck, Jr. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. | | ADDRESS Balto, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0932 | |
|--|-------------------------|---|---|--|---|
| C-236 71 0932 | | BIRTH NO. 71 0932 | | | |
| 1. NAME OF DECEASED (Type or Print) POMPEYA CASTRO | | 2. DATE AND HOUR OF DEATH 1/28/71 12:50 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION House in the Pines-Belair Rd. | | A. STATE Md. B. COUNTY | |
| | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 5614 Biddison Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 19, 1890. | 9. AGE (In years lost birthday) 80 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Spain | |
| 12. CITIZEN OF WHAT COUNTRY? Spain | | 13. FATHER'S NAME Francisco Zabala | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-14-0617D | | 17. INFORMANT Mrs. Constance Fernandez | |
| | | | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 174801-2-0-9 | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atelctatic Pneumonia (B) Metastatic Carcinoma (C) Carcinoma of the Breast | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days > 1 yr. 2 " | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Dilated multiple Renal Degeneration | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/1/70 to 1/28/71 that (I) (we) last saw the deceased alive on 1/27/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | 23B. DATE SIGNED 1/28/71 | | 23C. PHYSICIAN'S NAME (Type) Albert B. Bradley | |
| 23D. ADDRESS Belair Road | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71. | | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Zuber, Jr. | | 25C. FUNERAL DIRECTOR Geoffrey J. Ruck, Inc. Balto. Md. 21214 | |
| 25D. ADDRESS | | 25E. (City, town, or county) (State) | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0933 | |
|--|--|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> R-000 71 0933 </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANNETTE RAU | | | 2. DATE AND HOUR OF DEATH 1/28/71 5:30 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND. B. COUNTY 2735 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6551 GLENDALE AVE. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-22-1895 | 9. AGE (In years last birthday) 75 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY AMERICAN | | | 13. FATHER'S NAME CHARLES MILLER | | |
| 14. MOTHER'S MAIDEN NAME EMMA VINUP | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 218 44 3247 | | | 17. INFORMANT HOME ADDRESS | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. OBSTRUCTIVE JAUNDICE | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-11-71 19 to 1/28/71 19 that (I) (we) last saw the deceased alive on 1/28/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 1/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) [Signature] | | | | 23D. ADDRESS [Signature] | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-71 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. NAME OF REGISTRAR [Signature] | | 24F. FUNERAL DIRECTOR [Signature] | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR [Signature] | |
| 25D. ADDRESS Baltimore, Md | | | | | |



| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
|--|----------------------------------|---|--|--|--|--|--|---|--|
| EDNA B. GUINN | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year | | January 28, 1971 | | Hour M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | Month Day Year | | January 28, 1971 | | 7:10 A.M. | | | |
| 1839 Bolton Street | | A. STATE | | B. COUNTY | | Maryland | | 1901 | |
| 6. SEX | 7. RACE | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 9. DATE OF BIRTH | 10. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER | | 1839 Bolton Street | | | |
| Jan. 20, 1889. | 82 84x | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | |
| Kentucky | | USA | | Unknown | | Housewife | | Unknown | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | ADDRESS | | | |
| No | | | | Lynch-Stacy Funeral Home, Clarksburg, W. Va | | | | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 412.4 I | | Arteriosclerotic cardiovascular disease | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED | | 22F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 23. | | I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL EXAMINER'S NAME (Type) | | Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED | | January 28, 1971 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 2/2/71. | | Greenlawn Cemetery | | Clarksburg, W. Va. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| FEB 1 1971 | | Robert E. Taylor, Jr. | | Leonard J. Ruck, Inc. | | Balto. Md. 21214 | | | |

1880

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LIBRARY
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COMPARATIVE ZOOLOGY
AND
ANATOMY
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THE
MUSEUM
OF
COMPARATIVE ZOOLOGY
AND
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0935

BIRTH NO.

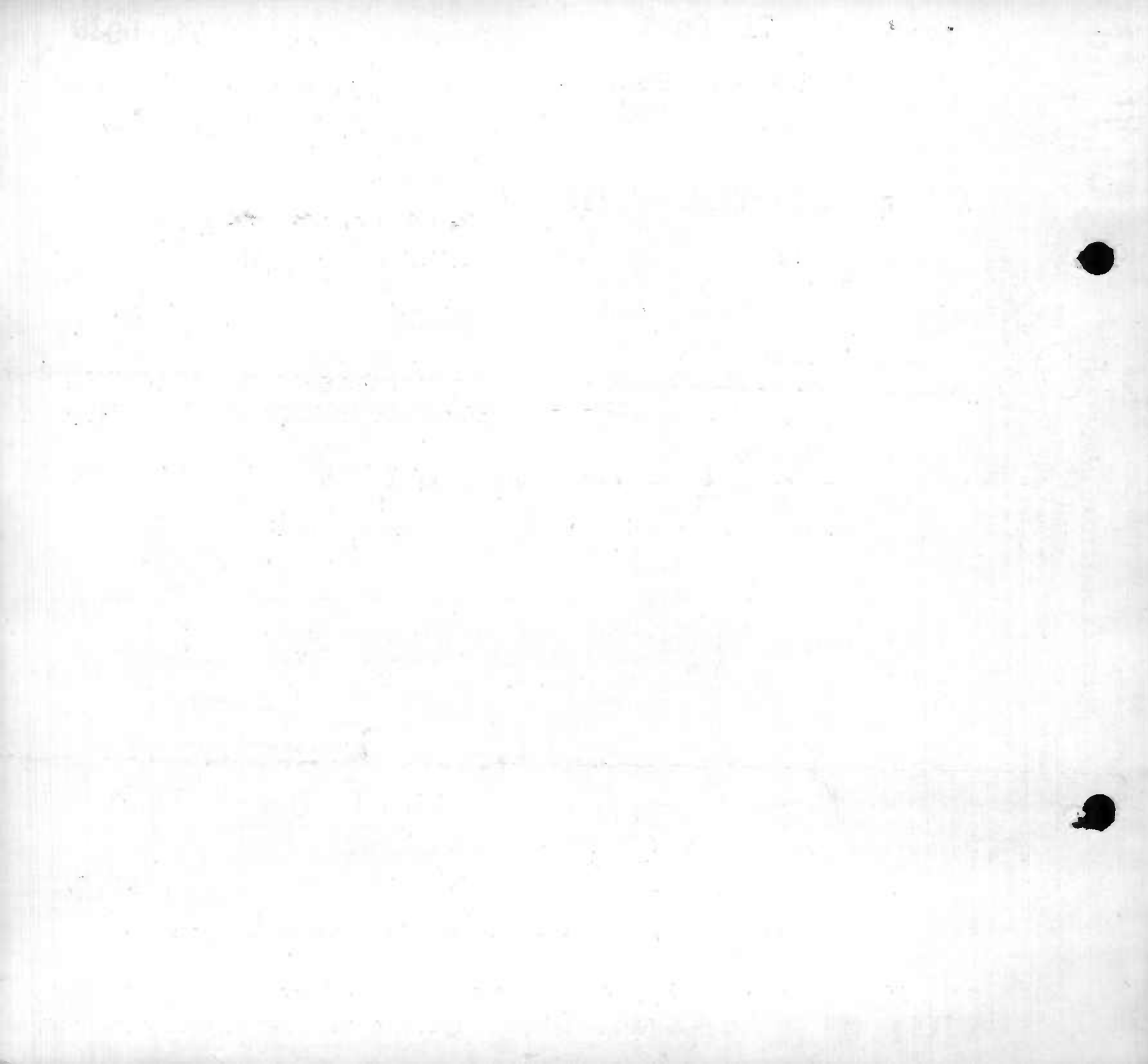
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) VERNON MORRISON ELY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4001 W. Belvedere Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 26 1971 8:15 p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH Dec. 13, 1956 | | 10. AGE (In years last birthday) 14 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. NO | |
| 18. INFORMANT John D. Costin | | ADDRESS 3503 Hayward Avenue 21215 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 1-26-71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) kitchen | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4001 W. Belvedere Ave. | | 22F. HOW DID INJURY OCCUR? Accidentally shot by friend. | |
| 22D. TIME OF INJURY (APPROX.) 1-26=71 p | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-27-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1-30-71 | |
| 24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. J. [unclear] | |
| 25C. FUNERAL DIRECTOR Armocost Funeral Chapel | | ADDRESS -4600 Liberty Hts | |

ACADEMIC RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

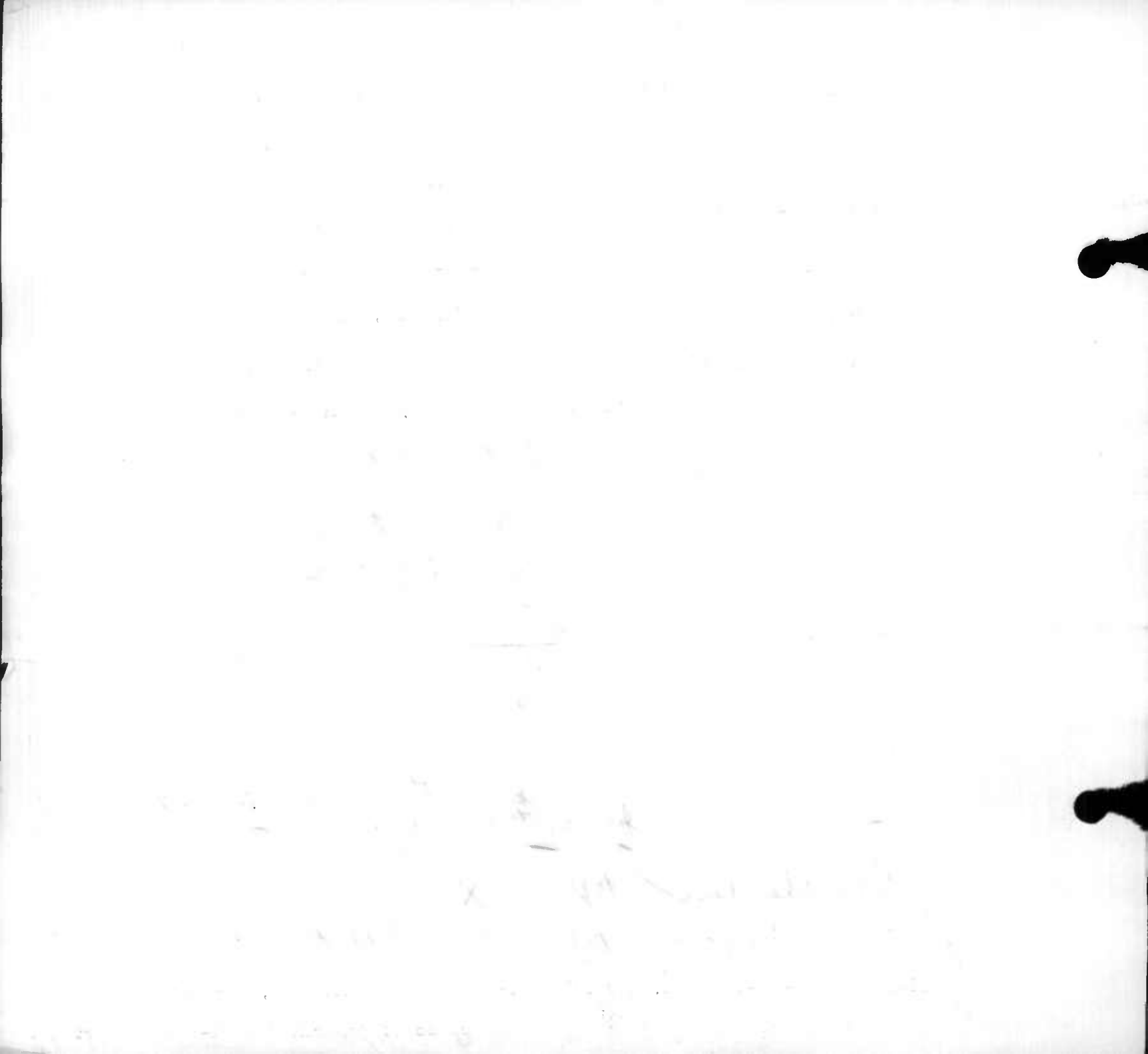
| | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|
| Baltimore City Health Department | | | | | | | | | |
| H-260 71 0936 | | | | | CERTIFICATE OF DEATH X REG. NO. 71 0936 | | | | |
| 1. NAME OF DECEASED (Type or Print) HOSIER, EDNA- FRANCES | | | | | 2. DATE AND HOUR OF DEATH 26 JANUARY 71 3:45 A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Wicomicot | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | | | | C. CITY OR TOWN Salisbury D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | E. STREET AND NUMBER Schumaker Drive, R.D. 3 | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/07/97 | | 9. AGE (In years lost birthday) 73 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee | | 10B. KIND OF BUSINESS OR INDUSTRY Food Processing | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? Usa | | |
| 13. FATHER'S NAME George I. Adkins | | | | | 14. MOTHER'S MAIDEN NAME Mary Cannon | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 214-12-4891 | | 17. INFORMANT (Daughter) Mrs. Roland Matthews, Kingston, Maryland | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 590.1 x 1 250.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RENAL FAILURE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. CHRONIC PYELONEPHRITIS & DIABETES | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II | | | | | | | | | |
| 19A. DATE OF OPERATION 1/7/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AMPUTATION NECROTIC FOOT | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/27/70 to 1/26/71 and that (I) (we) lost the deceased alive on 1/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Arthur Jenny, M.D. | | | | | 23B. DATE SIGNED 1/26/71 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Arthur Jenny, M.D. | | | | | 23D. ADDRESS The Johns Hopkins Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Jan. 28, 1971 | | 24C. NAME OF CEMETERY or CREMATORY Parsons Cemetery | | 24D. LOCATION (City, town, or county) (State) Salisbury, Wicomico, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Chae H. H. H. | | 25C. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-430 71 0937 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 0937 | |
|--|---------|--|------------------|--|--------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Sadye N Willhide | | January 27, 1971 3A-M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland | | Baltimore | |
| 00 3838 Roland Avenue | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 3838 Roland Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Female | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-21-1890 | 81 | 11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Bookkeeper | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Cornelius Willhide | | Effie Bittinger | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 212-10-3259 | | ADDRESS | |
| | | | | Janey W. Valentine-3838 Roland Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 2 days? | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 10 yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | - 5 yrs. | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 18th. 1971 to Jan. 27th. 1971 that (I) (we) last saw the deceased alive on Jan. 26th. 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Earl L. Chambers M.D. | | 1/29/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Earl L. Chambers - M.D. | | 100-W. Cold Spring Lane - Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 1-29-71 | | Mt. Oliver Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 1 1971 | | Robert E. Taylor, Jr. | | Armacost Funeral Chapel-4600 Liberty Hts | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-652 71 0938 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 71 0938 | |
|--|--|--|--|---|--|--|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | BARNES, EVELYN VIRGINIA | | JANUARY 27, 1971 | | 5:15P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE | | B. COUNTY | | | |
| 40 ST AGNES HOSPITAL | | | | MARYLAND | | | | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER | | | | | |
| | | | | 2218 ANNAPOLIS RD | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | |
| FEMALE | | WHITE | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 03/28/05 | | 65 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSEWIFE | | | | | | MARYLAND | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| ALLOYSIUS XXXXXXXX NOEL | | | | ANNA KEARNES | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | 213169924 | | BALTIMORE MD 21229 | | ST AGNES HOSPITAL WILKENS & CATON AVES | |
| 18. <u>250.9 I</u> CAUSE OF DEATH | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE | | <u>SEPTICEMIA</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES | | | | (B) | | <u>GLUTEAL ABSCESS</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO, OR AS A CONSEQUENCE OF: | | <u>DIABETIS MELLITUS</u> | | | |
| (C) | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | <u>ARTERIO SCLEROTIC HEART DISEASE</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 1-11-71 | | Hydrocephalus | | NO | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At: <input type="checkbox"/> Not While At Work: <input type="checkbox"/> | | | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>DECEMBER 18</u> 19 <u>70</u> to <u>JANUARY 27</u> 19 <u>71</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JANUARY 27</u> 19 <u>71</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>XXXX</u> view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| <u>Sabanayagam</u> | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| PONNAMPALAM SABANAYAGAM MD | | | | BALTIMORE MD 21229 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | | | 1-30-1971 | | Moreland Mem. Pk. Cemetery | | 2901 Taylor Ave., Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR'S ADDRESS | | | |
| FEB 1 1971 | | | | <u>Robert E. Hubert, Jr.</u> | | <u>Howard H. Hubbard</u> | | 4107 Wilkens Ave. 21229 | |

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| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
|---|--|--|--|--|--|---|--|---|--|
| AVANCE FELDER | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | | Month Day Year Hour | | A. STATE B. COUNTY | |
| 43 | | | | 1 22 1971 9:40 p.m. | | South Balto. Gen. Hospital | | Md. 2201 | |
| 6. SEX male | | 7. RACE negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) 52 | | 11. BIRTHPLACE (State or foreign country) S-C. | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| | | | | | | 18. INFORMANT Ada Williams-2520 Lafayette Ave | | ADDRESS | |
| 19. 571.8 I | | CAUSE OF DEATH | | Fatty metamorphosis of liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 24. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Isaiah L. Brown & Son | | 25C. FUNERAL DIRECTOR 123 W. Montgomery Street | | 25D. ADDRESS | | | |

ADAM E. SMITH - F.D.M.

WALTER E. SMITH - F.D.M.

John C. Smith

Isabel A. Brown - Son
John C. Smith - Son

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

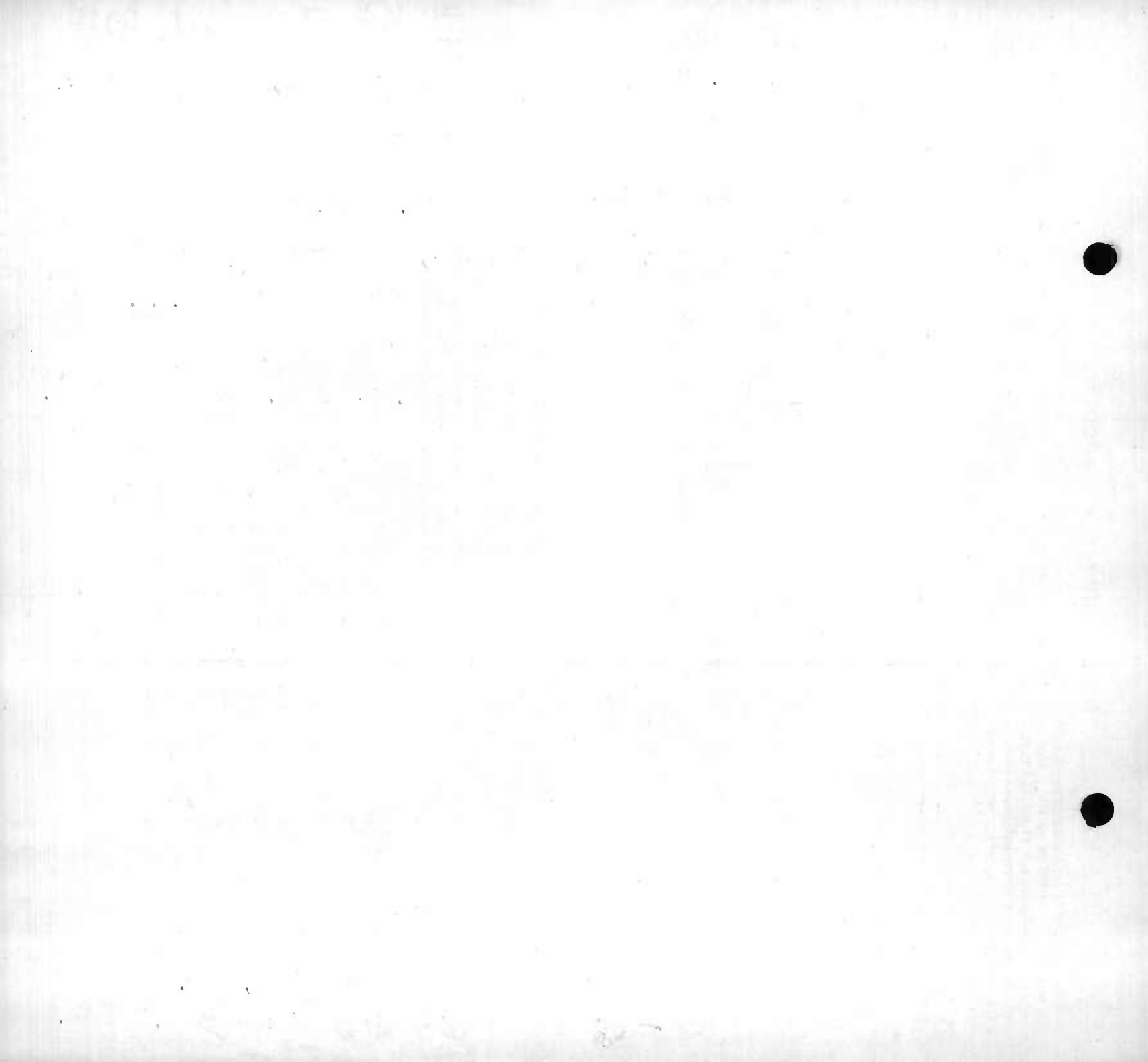
| F-626 | | 71 0940 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 71 0940 | |
|--|--|---|--|---|--|---|--|---|--|
| BIRTH NO. | | 71 0940 | | CERTIFICATE OF DEATH | | REG. NO. | | 71 0940 | |
| 1. NAME OF DECEASED (Type or Print) <i>Frazier Mrs Dorothy O.</i> | | | | 2. DATE AND HOUR OF DEATH <i>1/27/71 - 8:45 P.M.</i> | | | | | |
| 3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>CHURCH HOME AND HOSPITAL 35 BALTIMORE - 2/231</i> | | | | A. STATE <i>MARYLAND</i> | | B. COUNTY <i>BALTIMORE</i> | | C. CITY OR TOWN <i>BALTIMORE</i> | |
| | | | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 5. SEX <i>F</i> | | | | 6. RACE <i>W</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>4-1-22</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Life Typist, Mont. Ward. Co.</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Norman Perkins</i> | | | | 14. MOTHER'S MAIDEN NAME <i>LENORA COREY</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>216-16-8615</i> | | 17. INFORMANT <i>Mr. Robert L. Frazier</i> | | | |
| | | | | 17. ADDRESS <i>7600 WILHELM AVE</i> | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Peritonitis, mesenteric</i> | | | | CAUSE OF DEATH <i>Carcinoma of Cervix.</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Months</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <i>1/14/71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Peritonitis</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-28-1971</i> to <i>1-27-1971</i> that (I) (we) lost saw the deceased alive on <i>1-27-1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>T. S. R. E. RAMANATHY</i> | | | | 23B. DATE SIGNED | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>T. S. R. E. RAMANATHY</i> | | | | 23D. ADDRESS <i>CHURCH HOME AND HOSPITAL</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/31/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Bethesda Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Morristown, Tennessee</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1971</i> | | 25B. NAME OF REGISTRAR <i>John E. Frazier</i> | | 25C. FUNERAL DIRECTOR <i>John E. Frazier</i> | | 25D. ADDRESS <i>3000 E. Baltimore St</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0941 | |
|--|--|---|---|--|---|
| BIRTH NO. D-400 | | 71 0941 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Oscar C. Diehl | | | 2. DATE AND HOUR OF DEATH January 28, 1971 7:30 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2301 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 113 W. Ostend Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 14, 1905 | 9. AGE (In years lost birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright | | 10B. KIND OF BUSINESS OR INDUSTRY General Motors | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Homer Diehl | | |
| 14. MOTHER'S MAIDEN NAME Nannie Henson | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Rometa E. Diehl ADDRESS 113 W. Ostend Street Balto. | | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterio-sclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic disease (C) </div> <div style="width: 10%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/2/68 19 to 1/28/71 19 that (I) (we) last saw the deceased alive on 1/28/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ricardo Lozada | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) RICARDO LOZADA | | | | 23D. ADDRESS 1218 S. Charles A. Baltimore, Md. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 25B. NAME OF REGISTRAR R. E. ... 25C. FUNERAL DIRECTOR Mc Call Funeral Home ADDRESS 130 E. Fort Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0942</u> | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. <u>B-400</u> | | 71 0942 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>FRANCES O. BAILEY</u> | | | 2. DATE AND HOUR OF DEATH <u>1/27/71</u> <u>9²⁵</u> A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> | | | A. STATE <u>PENNA.</u> B. COUNTY <u>YORK</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>DELTA</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| <u>48</u> | | | E. STREET AND NUMBER <u>MAIN STREET</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/20/89</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 11. BIRTHPLACE (State or foreign country) <u>TARIFF, W. VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>WILLIAM C. ELLIS</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARY JANE SMITH</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>248-01-12862</u> | | 17. INFORMANT <u>MRS. C. PARKE SCARBOROUGH, JR.</u> |
| | | | ADDRESS <u>DELTA, PA.</u> | | |
| 18. <u>162.11</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Circumstances ? Lung</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>arteriosclerosis CVD</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED (White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>) | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1970</u> 19 <u>70</u> to <u>1/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/26</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W. H. Townsend</u> | | | | 23B. DATE SIGNED <u>1/27/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>W. H. TOWNSEND</u> | | | | 23D. ADDRESS <u>14 E. Engle St. Baltimore Md</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-30-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>SLATEVILLE</u> | |
| 24D. LOCATION <u>DELTA, YORK CO., PA.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 24F. NAME OF REGISTRAR <u>JOHN H. HARKINS</u> | |
| 24G. ADDRESS <u>DELTA, PA.</u> | | 24H. NAME OF REGISTRAR <u>JOHN H. HARKINS</u> | | 24I. ADDRESS <u>DELTA, PA.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0943 | |
|---|-------------------------|---|--|---|---|
| H-652 71 0943 BIRTH NO. 1. NAME OF DECEASED (Type or Print) MICHAEL HIRNIAK | | 2. DATE AND HOUR OF DEATH Jan. 28, 1971 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1613 Popland Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-05 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1613 Popland St. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 12, 1896 | 9. AGE (In years last birthday) 74 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Mon. Rubber Co. | | 11. BIRTHPLACE (State or foreign country) Ukraine | |
| 12. CITIZEN OF WHAT COUNTRY? Ukraine | | 13. FATHER'S NAME Philip Hirniak | | | |
| 14. MOTHER'S MAIDEN NAME Unk | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Hirniak 1613 Popland St. | | | |
| CAUSE OF DEATH | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 162.1 I Brands pneumonia Carcinoma of the Lung E metastases | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Brands pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Lung E (C) metastases | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 9-mos. | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 1970 to Jan 28 1971 , that (I) we last saw the deceased alive on January 12 1971 and that in (my) the opinion death occurred on the date and hour and from the causes stated above. (I) we (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George J. Richards Jr. MD | | 23B. DATE SIGNED 1/29/71 | | 23C. PHYSICIAN'S NAME (Type) George J. Richards Jr MD | |
| 23D. ADDRESS Greater Baltimore Med Center | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 2/1/71 | | 24C. NAME OF CEMETERY OR CREMATORY Victoria Lawn Cem. | | 24D. LOCATION (City, town, or county) (State) St. Catherines, Ontario | |
| 25A. DATE RECEIVED BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Blue E. Kelly | | 25C. FUNERAL DIRECTOR Main Funeral Home, 4200 Pennington Ave | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-252 71 0944 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0944 | |
|---|-------------------------|---|---|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Buchness, Frances M.</i> | | | | 2. DATE AND HOUR OF DEATH <i>1-27-71 9:31 AM</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>423 South Baltimore Street</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i> <i>52-00</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore Street Hospital</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>Glen Burnie</i> | | D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER <i>700 Central Avenue</i> | | | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-20-99</i> | 9. AGE (in years last birthday) <i>71</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Reichenbach, Conrad S.</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Creamer, Catherine</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>215-07-0412-B</i> | | 17. INFORMANT <i>Husband, Joseph</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>151-901-250-9</i> | | | CAUSE OF DEATH <i>G.I. (Gastro-intestinal haemorrhage)</i> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gastric ulcer (? Malignant)</i> | | | (B) DUE TO, OR AS A CONSEQUENCE OF: <i>(C)</i> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Arteriosclerotic heart disease, Diabetes Mellitus</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>1-27-71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>YES</i> | | 20A. AUTOPSY (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-21-71</i> 19 to <i>1-27-71</i> 19 that (we) lost saw the deceased alive on _____ 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Aye Ngwe</i> M.D. | | | | 23B. DATE SIGNED <i>1-27-71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Aye Ngwe</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>1/30/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i> | | 24D. LOCATION (City, town, or county) (State) <i>Glen Burnie Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i> | | 25C. FUNERAL DIRECTOR <i>Singleton</i> | | ADDRESS <i>Singleton Funeral Home Glen Burnie Md.</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0945 | |
|---|--|---|--|---|--|
| B-400 71 0945 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Howard E Riley Sr</i> | | 2. DATE AND HOUR OF DEATH <i>1-29-71</i> <i>7 A. M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2028 Booth Street</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>2003</i> | | | |
| 5. SEX <i>Male</i> | | 6. RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <i>5-12-1901</i> | | 9. AGE (In years last birthday) <i>69</i> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MAINTENANCE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>General</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Wm Riley</i> | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | |
| 16. SOCIAL SECURITY NO. <i>218-10-3082</i> | | 17. INFORMANT <i>Howard E Riley Jr. 787 Bridge Dr Pasadena Md</i> | | | |
| 18. <i>412.13 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerotic Heart Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1965</i> to <i>Jan 29 1971</i> , that (I) (we) last saw the deceased alive on <i>Jan 15 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Morris B. Schreiber M.D.</i> | | 23B. DATE SIGNED <i>1-29-71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>MORRIS B. SCHREIBER M.D.</i> | |
| 23D. ADDRESS <i>1519 W. Lombard St. Baltimore Md.</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | |
| 24B. DATE <i>2-1-71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, Md.</i> | | 25C. FUNERAL DIRECTOR <i>Inc 1600 Hollins St</i> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0946 | | REG. NO. | |
|---|---------------------|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) SZACHNOWICZ, ANNA | | | | 2. DATE AND HOUR OF DEATH 1-27-71 1945 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MD. | | B. COUNTY 843 | |
| C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 1213 Light Street | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-4-80 | | 9. AGE (in years lost birthday) 90 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Denion Igangehak | | | | 14. MOTHER'S MAIDEN NAME Andrachuch | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-30-7786-D | | 17. INFORMANT MR. ALEKSY SZACHNOWICZ | | | |
| 18. CAUSE OF DEATH Septicemia 2d. side Pneumonia Wounds & ulcers | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPT? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 25th 19 71 to Jan 27th 19 71 that (I) (we) last saw the deceased alive on Jan 27th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Nedeljko Matesic MD | | | | 23B. DATE SIGNED Jan 27th 71 | | 23C. PHYSICIAN'S NAME (Type) NEDELJKO MATESIC | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1-30-71 | | 24C. NAME of CEMETERY or CREMATORY ST. ANDREWS GEM. | | 24D. LOCATION (City, town, or county) (State) BALTO. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Charles E. Kelly | | 25C. FUNERAL DIRECTOR BERNARD DOBROWSKI F.H. 2818 E. BALTO. ST. | | ADDRESS | |

11/3/70 1333 S. Linwood Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-----------------------------|---|--|--|---|
| F-435 71 0947 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0947 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) JOHN FELDMAN | | 2. DATE AND HOUR OF DEATH 1/25/71 9:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 602 | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 144 N. Luzerne Ave. | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-23-01 | 9. AGE (In years last birthday) 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPFITTER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME JACOB | | 14. MOTHER'S MAIDEN NAME MARY | | 17. INFORMANT MARY FELDMAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-01-3097 | | ADDRESS 144 N. Luzerne Ave | |
| 18. 400.21 + 303.2 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | Cerebrovascular accident | | undetermined | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Malignant hypertension | | (B) DUE TO, OR AS A CONSEQUENCE OF: year | |
| (C) | | Alcoholism, Chronic | | year | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25/71 to 1/25/71 that (I) (we) last saw the deceased alive on 1/25/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm Maniago, M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/25/71 | |
| 23C. PHYSICIAN'S NAME (Type) WILMA B. MANIAGO, M.D. | | 23D. ADDRESS CHURCH HOME & HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 1-29-71 | 24C. NAME OF CEMETERY OR CREMATORY Holy Rospary Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR John E. J. B. R. | | 25C. FUNERAL DIRECTOR BDabrowski | |
| | | | | ADDRESS 2818 E Balto. St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

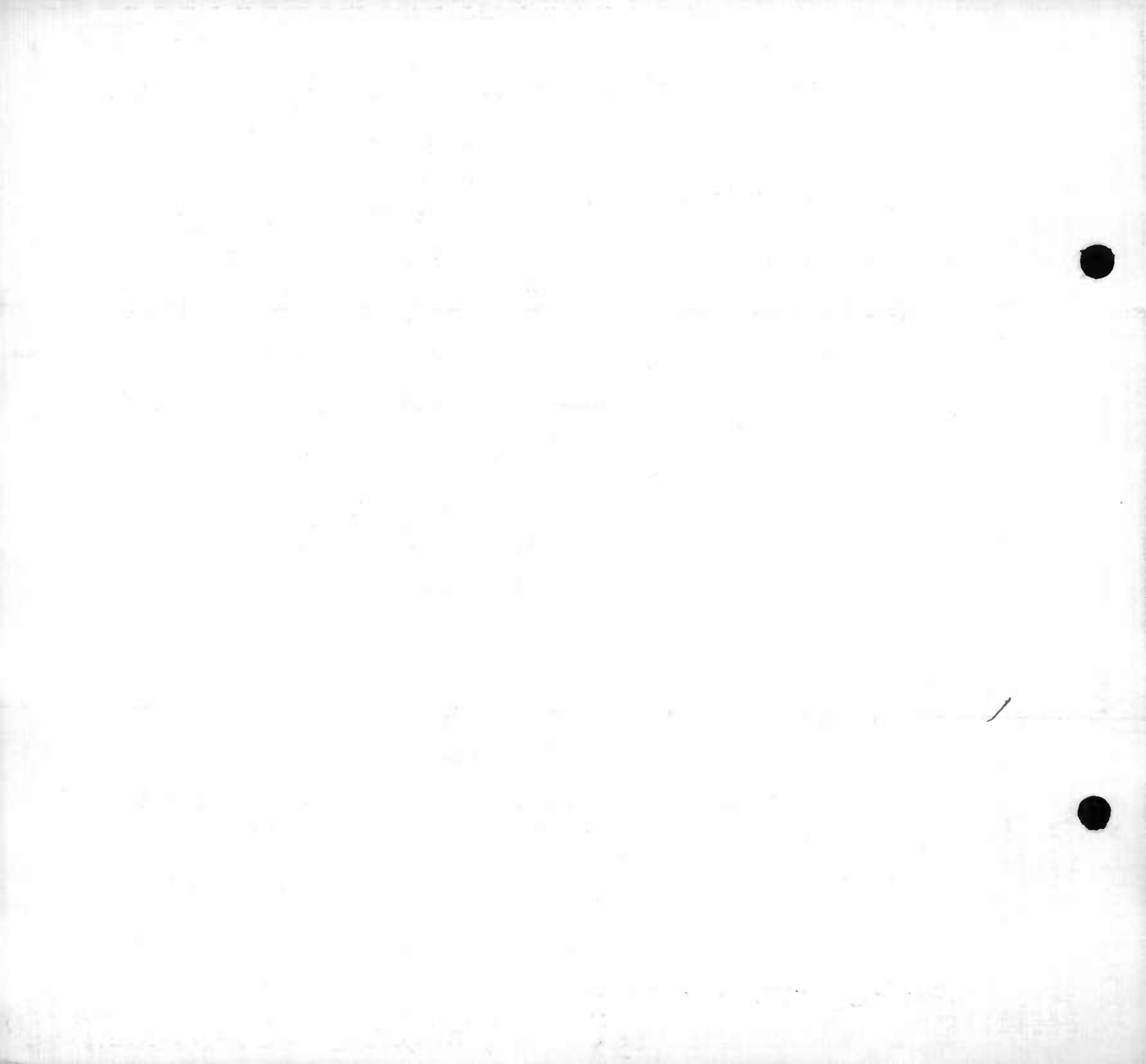
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0948</u> | |
|--|--|---|--|---|--|
| H-255 71 0948 | | CERIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>WILLIAM A. HASSMANN</u> | | 2. DATE AND HOUR OF DEATH <u>1-28-71</u> <u>6:10 P. M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence, before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Edgewood Gravalant Home</u> | | A. STATE <u>Maryland</u> | | B. COUNTY <u>703</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>8-28-86</u> | | 9. AGE (In years last birthday) <u>84</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R Grocer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Unknown</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217482957</u> | |
| 17. INFORMANT <u>Elizabeth Catterton</u> | | ADDRESS <u>6806 Dunbar Rd.</u> | | | |
| 18. <u>410.91</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Arteriosclerotic Heart disease</u> | | DUE TO, OR AS A CONSEQUENCE OF: <u>7 years</u> | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>Jan 28 1971</u> to <u>19</u> that (H) (we) last saw the deceased alive on <u>Jan 28 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Frederick J. Vollmer MD</u> | | | | 23B. DATE SIGNED <u>1-28-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER MD</u> | | | | 23D. ADDRESS <u>6100 York Rd. Baltimore Md 21212</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-30-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | |
| 24D. LOCATION <u>Baltimore Maryland</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | | |
| 24F. NAME OF REGISTRAR <u>Robert E. [illegible]</u> | | 24G. FUNERAL DIRECTOR <u>John E. [illegible]</u> | | | |
| 24H. ADDRESS <u>1241 Chesapeake Ave.</u> | | | | | |

10 2022

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|---|---|--|
| 71 0949 CERTIFICATE OF DEATH | | | | | | | | | | | |
| REG. NO. 71 0949 | | | | | | | | | | | |
| BIRTH NO. <u>A-553</u> | | 1. NAME OF DECEASED (Type or Print) <u>Ament, Margaret</u> | | | | 2. DATE AND HOUR OF DEATH <u>1/28/71</u> <u>10:11 a.m.</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp.</u> | | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | | | |
| | | | | | | C. CITY OR TOWN <u>Baltimore</u> | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER <u>8108 Bon Air Road</u> | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>01-21-01</u> | | 9. AGE (In years last birthday) <u>70</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Frank Frietsch</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Cheseldine</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Dorothy Freburger</u> | | | |
| | | | | | | ADDRESS <u>2936 Berk Lake Baltimore</u> | | | | | |
| 18. <u>42401</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Possible Pulmonary Embolus</u> | | | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u> (B) <u>Mitral Valve Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (C) <u>—</u> | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u> | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1/25/71</u> 19 <u>71</u> to <u>1/28</u> 19 <u>71</u> that (I) <u>(we)</u> lost saw the deceased alive on <u>1/28/71</u> 19 <u>71</u> and that (in my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>H. Earl Cotman, M.D.</u> | | | | | | 23B. DATE SIGNED <u>1/28/71</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>H. Earl Cotman, M.D.</u> | | | | | | 23D. ADDRESS <u>Union Memorial Hosp.</u> | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/1/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Gardens Balto</u> | | | | 24D. LOCATION (City, town, or county) <u>Balto</u> | | 24E. (State) <u>2nd</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Philip E. Grach</u> | | | | 25C. FUNERAL DIRECTOR <u>Philip E. Grach</u> | | ADDRESS <u>1211 Chesapeake Ave</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPT. | | | | REG. NO. 71 0950 | | | |
|--|---------------------|---|--|--|--|---|--|
| 1 M-320 71 0950 | | | | BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Clarence Charles E. Maddox | | | | 2. DATE AND HOUR OF DEATH Jan. 27, 1971 8:30 P.M. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3019 Belair Rd. | | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3019 Belair Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 29, 1901 | | 9. AGE (In years last birthday) 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator | | | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. | | 11. BIRTHPLACE (State or foreign country) Chase, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | 13. FATHER'S NAME unknown | | | |
| 14. MOTHER'S MAIDEN NAME unknown | | | | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) yes | | | |
| 16. SOCIAL SECURITY NO. 212-03-1666 | | | | 17. INFORMANT ADDRESS Mrs. Mildred Maddox, 3019 Belair Rd. | | | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma Prostate ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Atherosclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs - 6-12 m | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 1-27-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-27-71 to 1-27-71 , that (I) (we) last saw the deceased alive on 1-27-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William L. Fearing MD | | | | 23B. DATE SIGNED 1-29-71 | | 23C. PHYSICIAN'S NAME (Type) Dr. Wm. L. Fearing | |
| 23D. ADDRESS 3025 Belair Rd., Balto., Md. 21213 | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | | |
| 24B. DATE Jan. 30, 1971 | | | | 24C. NAME of CEMETERY or CREMATORY Meadowridge | | | |
| 24D. LOCATION Balto., Md. | | | | 25A. DATE RECEIVED BY HEALTH DEPT. FEB 1 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fearing | | | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, 3331 Brehms Lane Balto., Md. 21213 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0951 | |
|--|---------|--|--|--|---|
| <div style="display: flex; justify-content: space-between;"> K-100 71 0951 71 0951 </div> | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| ROBERT D. KIPP | | | 1/26/71 10 a. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 90 Edgewood Nursing Home | | | Md. 21213 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 3311 Clifftmont Ave. | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| male | white | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12/7/88 | 82 | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Sheet Metal Worker | | | Beth. Steel | | Baltimore, Md. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| George Kipp | | | Mary Erdman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| no | | | 212-01-4471A | | Mary Vogt Kipp, wife, above |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 1888 I | | | CANCER of the Bladder | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-22-1971 to 1-26-1971 that (I) (we) last saw the deceased alive on 1-25-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Anthony F. Carozza | | | | 1-26-1971 | |
| 23C. PHYSICIAN'S NAME (Type or Print) | | | | 23D. ADDRESS | |
| Anthony F. Carozza | | | | 5212 York Rd Balto Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/29/71 | | Parkwood Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 1 1971 | | Robert E. Taylor, M.D. | | Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



CERTIFICATE OF DEATH

REG. NO.

3971-0952

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bigham, James E

2. DATE AND HOUR OF DEATH

1/26/71

11:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Baltimore City Hospitals4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

614 South East Avenue 21224

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-15-00

9. AGE (in years last birthday)

70

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

retired janitor

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. II Army

16. SOCIAL SECURITY NO.

087-22-7613A

17. INFORMANT

4940 Eastern Avenue
Baltimore, Maryland 21224
BCH: Records

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:(B) ASCVD
DUE TO, OR AS A CONSEQUENCE OF:

(C) S/P insertion demand packmaker

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 week

14 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/13/71 to 1/26/71 that (we) lost saw the deceased alive on 1/26 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Chasis, M.D.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

1/27/71

23C. PHYSICIAN'S NAME (Type)

J. Chasis M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

burial

24B. DATE

1/30/71

24C. NAME OF CEMETERY OR CREMATORY

Holly Hill Cemetery

24D. LOCATION

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 1 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Schimineck Funeral Home, 3331 Brehms Lane

ADDRESS

Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1943

1944

1945

1946

1947

1948

1949

1950

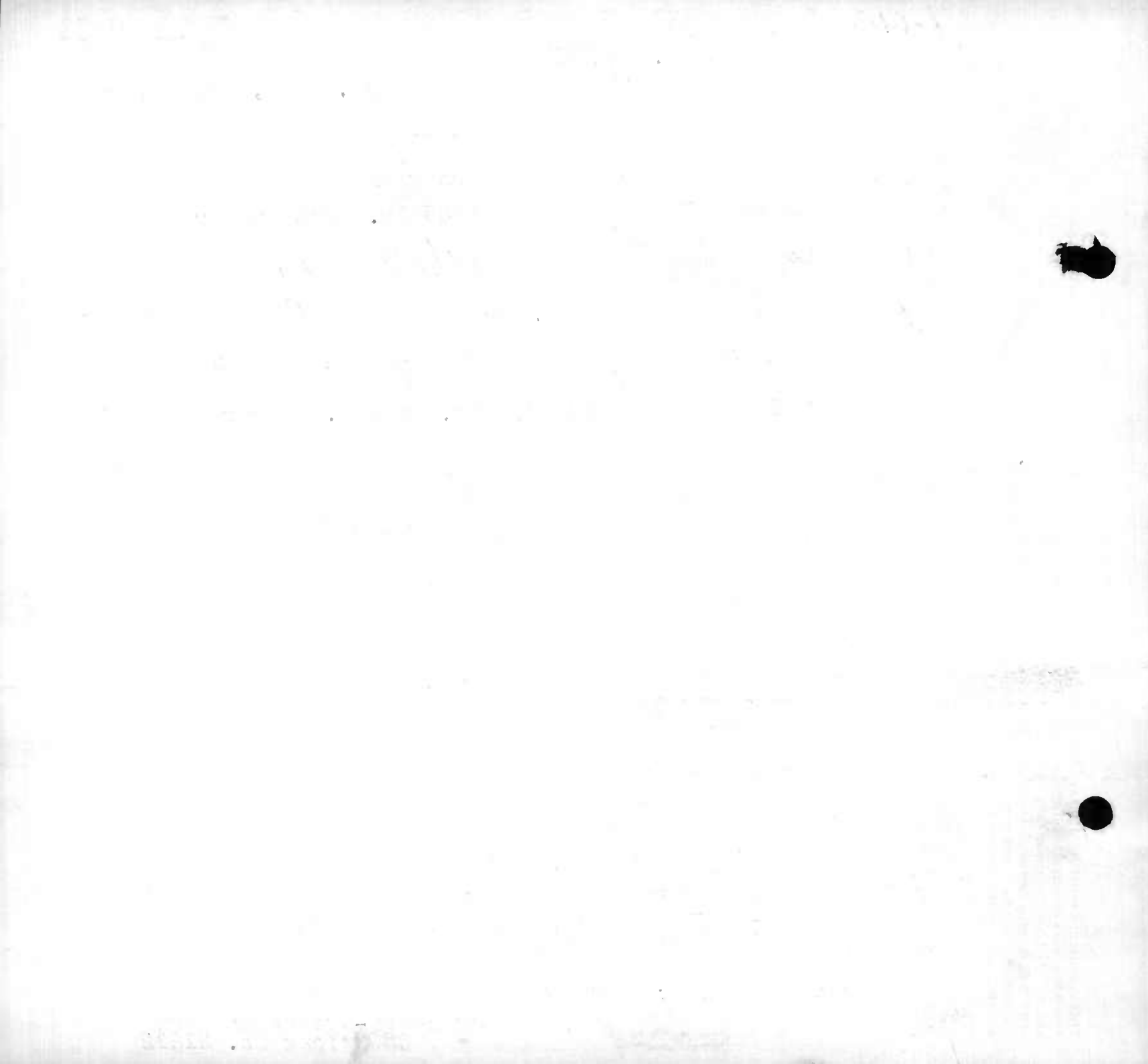
1951

(1952-1953)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

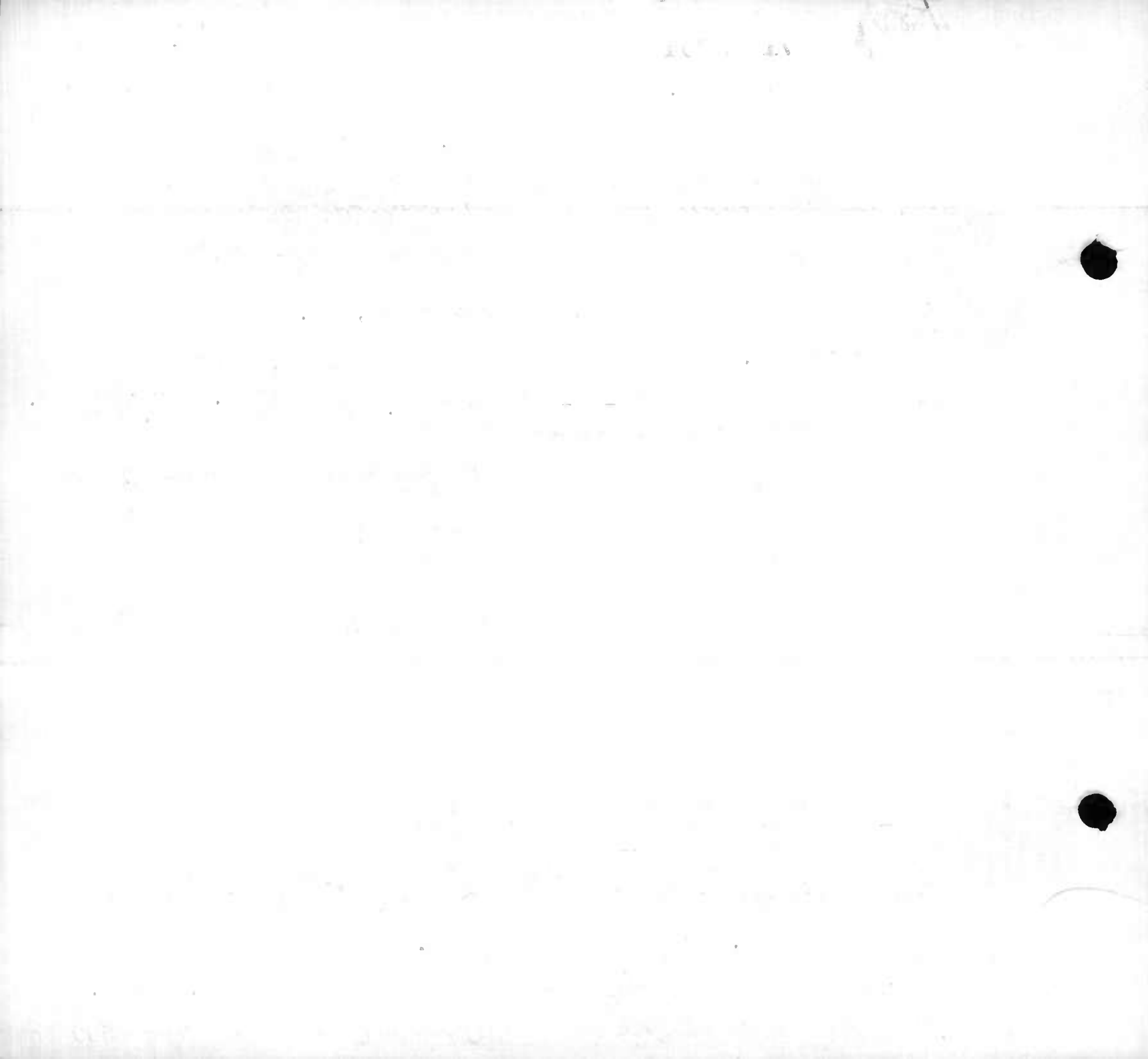
| | | | | | | | |
|---|--|--|--|---|--|--|--|
| H-610 | | 71 0953 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0953 | |
| BIRTH NO. HAROLD L. HARVEY | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Harold L. Harvey | | | | 2. DATE AND HOUR OF DEATH JAN. 14TH, 1971 9:10 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital 33rd Calvert | | | | A. STATE MARYLAND B. COUNTY 1202 | | | |
| 5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 7/7/99 | | 9. AGE (in years lost birthday) 71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Engineering-Research | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Harry D. Harvey | | | | 14. MOTHER'S MAIDEN NAME Mary Wilkins | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI & II | | | | 16. SOCIAL SECURITY NO. 216-31-5323 | | 17. INFORMANT ADDRESS MRS. RUBY M. HARVEY - SAME | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronal thrombosis | | 17hr | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/2/62 to 1/14/71 that (I) (we) last saw the deceased alive on 1/14/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William F. Renner | | | | 23B. DATE SIGNED 1/14/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM F. RENNER | | | | 23D. ADDRESS 3222 ST Paul ST Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/16/71 | | 24C. NAME of CEMETERY or CREMATORY : OUDON PARK CEM | | 24D. LOCATION (City, town, or county) (State) BALTO | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME | | ADDRESS 6500 York Rd. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

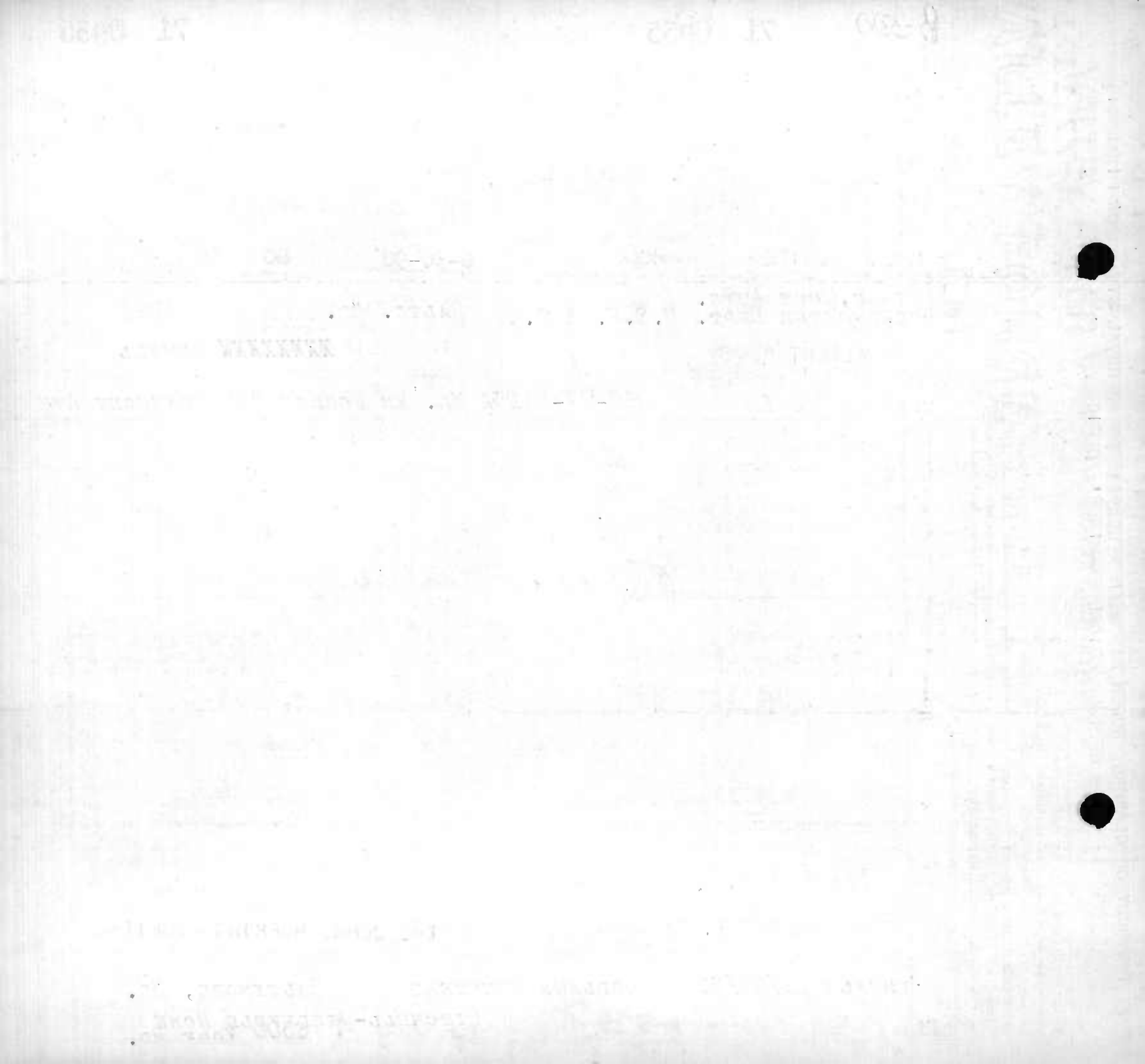
| | | | | | | | | | |
|--|---|---|---|---|----------------------------|---|-----------------------------|--|--|
| BIRTH NO. H-400 | | 71 0954 | | Baltimore City Health Department | | CERTIFICATE OF DEATH | | REG. NO. 71 0954 | |
| 1. NAME OF DECEASED (Type or Print) ROSABEL E. HALL | | | | 2. DATE AND HOUR OF DEATH 1/21/1971 5:35 A M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 ANDERSON NURSING HOME 3604 MOHAWK AVE | | | | A. STATE MD. | | B. COUNTY BALTIMORE | | C. CITY OR TOWN BALTIMORE | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 3604 MOHAWK AVE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/8/1887 | 9. AGE (In years lost birthday) 83 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRUANT OFFICER | | | | 10B. KIND OF BUSINESS OR INDUSTRY EDUCATION | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM R. HALL | | | | 14. MOTHER'S MAIDEN NAME MARGARET E. PARKER | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 215-48-7775 | | 17. INFORMANT ROGER F. HALL | | ADDRESS 317 E. WHEELING ST. LANCASTER, OHIO | |
| 18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction 2 day OCD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 9 I bleeding | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nailly medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5 19 65 to present 19 71 that (I) (we) last saw the deceased alive on 12-4 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Leonard Katz / pr Steinbach | | | | | | | | 23B. DATE SIGNED 1/21/71 | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY R. STEINBACH | | | | 23D. ADDRESS 11 W. SLADE AVE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/23/71 | | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY | | 24D. LOCATION (City, town, or county) (State) FREDERICK RD. BALTO. MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taber, M.D. | | 25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD HOME | | ADDRESS 6500 YORK | | | |



THE BODY OF CLARENCE BOWEN HAS BEEN RELEASED ON APPROVAL BY
OF THE MEDICAL DIRECTOR'S OFFICE
DR MIHALAKIS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

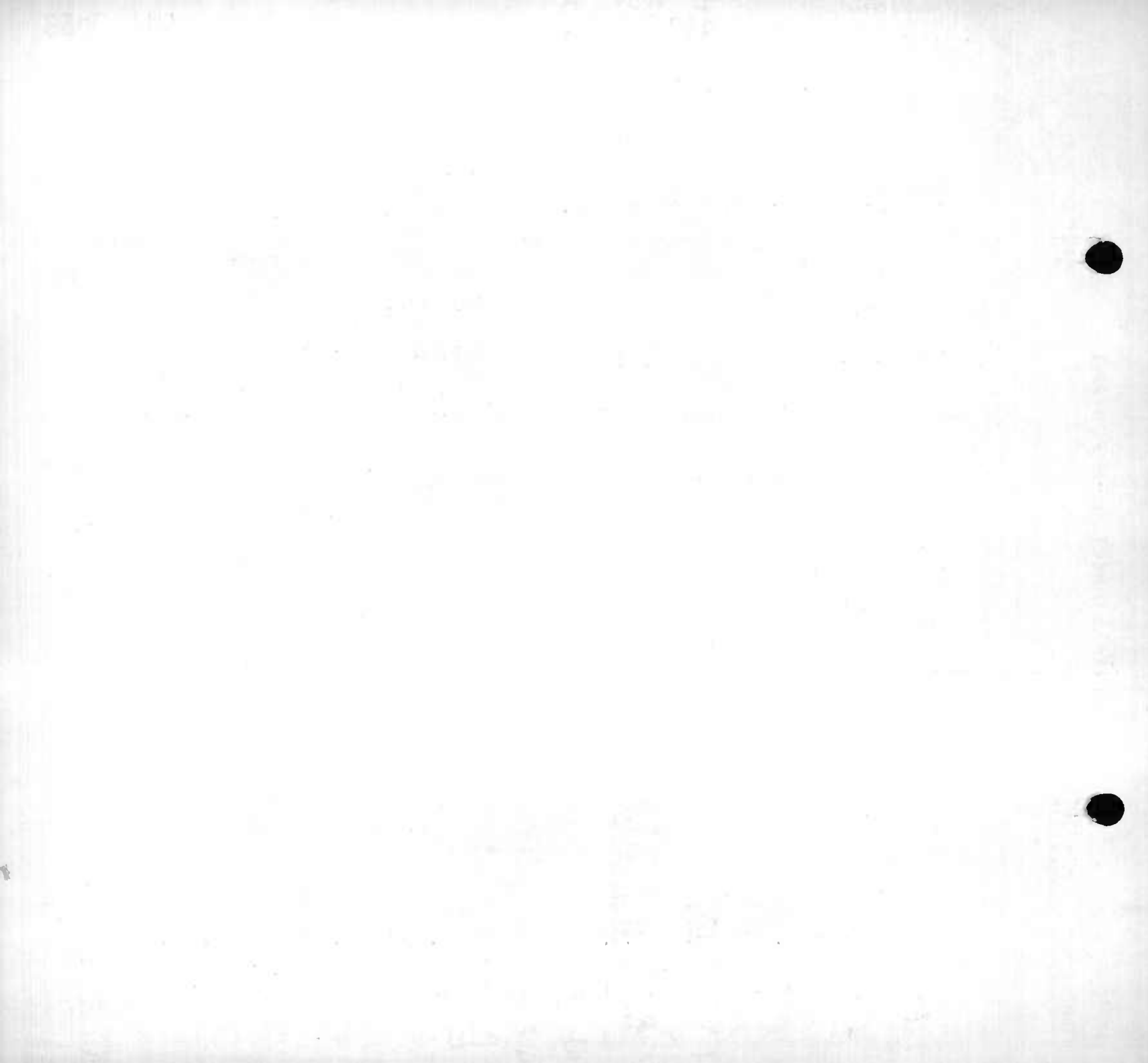
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|---|--|---|--|---|--|---|--|---|--|--|--|
| B-500 | | 71 0955 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0955 | | | | | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) CLARENCE BOWEN | | | | 2. DATE AND HOUR OF DEATH 1/17/71 2:50 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL | | | | C. CITY OR TOWN BALTIMORE | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 817 BEAUMONT AVENUE 2710 | | | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-30-90 | | 9. AGE (In years last birthday) 80 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED, SUPPLY AUTO UNDERWRITER DEPT. U.S.F. & G. | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ALBERT BOWEN | | | | 14. MOTHER'S MAIDEN NAME JULIA HEWELL | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I | | | | 16. SOCIAL SECURITY NO. 215-07-8415A | | 17. INFORMANT MR. WM NORRIS 817 BEAUMONT AVE | | | | ADDRESS | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) CONTINUAL ASPIRATION OF STOMACH CONTENTS esophageal diverticulum ASCVD | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 7 mos 2 yrs | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION 3/19/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED dysphagia & aspiration | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes 422 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 29, 1970 to Jan 17, 1971, that (I) (we) last saw the deceased alive on Jan 16, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Robert T. Snowden, MD | | | | 23B. DATE SIGNED Jan 17, 1971 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT T. SNOWDEN | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/20/71 | | 24C. NAME OF CEMETERY or CREMATORY WOODLAWN CEMETERY | | 24D. LOCATION BALTIMORE, MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME | | ADDRESS 8500 YORK RD. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0956 | |
|---|----------------------------|---|---|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) MARY ELEANOR Meeth, Miss Maysie | | 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 1-26-71 330 PM M. </div> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) KESWICK 700 West 40th Street, Baltimore, Md. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1307 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 40th + Keswick | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/10/80 | 9. AGE (In years lost birthday) 90 years | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Maryland, USA | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John H. Meeth | | | 14. MOTHER'S MAIDEN NAME Elizabeth Schreiber | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-52-0593 | | 17. INFORMANT Mrs A. P. Bunnell Jr., Whitman, Ind. | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 15%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 12 yrs 14 yrs </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: (C) Atherosclerotic Cardiovascular Disease </div> <div style="width: 15%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 12 yrs 14 yrs </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9 Apr 1960 to 26 Jan 1971, that (I) (we) last saw the deceased alive on 26 Jan 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aubrey D. Richardson M.D. | | | | 23B. DATE SIGNED 26 Jan 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson M.D. | | | | 23D. ADDRESS 700 W. 40th St. Baltimore, Md. 21211 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/28/71 | | 24C. NAME OF CEMETERY OR CREMATORY Louisa Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Robert E. ... | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

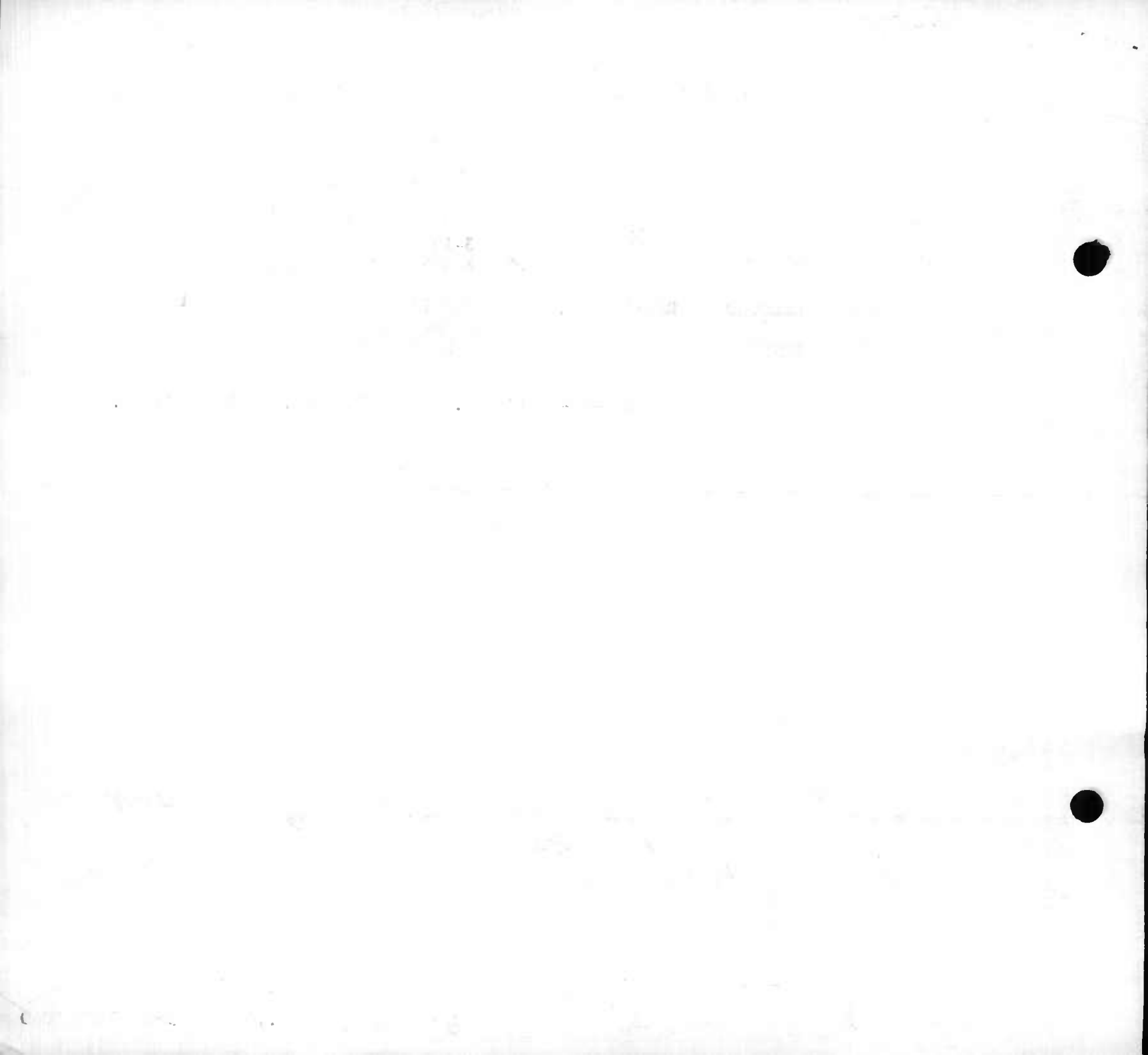
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0957 |
|--|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) PAULINE P. WHITE | | 2. DATE AND HOUR OF DEATH January 28, 1971 6 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1422 Gittings Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2238 | | |
| 5. SEX female | | 6. RACE caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH April 16, 1894 | | 9. AGE (In years last birthday) 76 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Jacob XXXXX Webster | | |
| 14. MOTHER'S MAIDEN NAME Frances Walters | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 218-50-8053 | | 17. INFORMANT ADDRESS Mrs. Shirley Dodson (Same) | | |
| 18. CAUSE OF DEATH 418.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary fibrosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 15 November 1966 to 28 January 1971 that (I) (we) last saw the deceased alive on 9 October 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE John W. Barnaby | | 23B. DATE SIGNED 28 Jan 71 | | 23C. PHYSICIAN'S NAME (Type) DR. JOHN W. BARNABY |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | |
| 25B. NAME OF REGISTRAR Robert E. Vabey, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS Deo Ruck, Inc. - Balto, Md. - 14 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

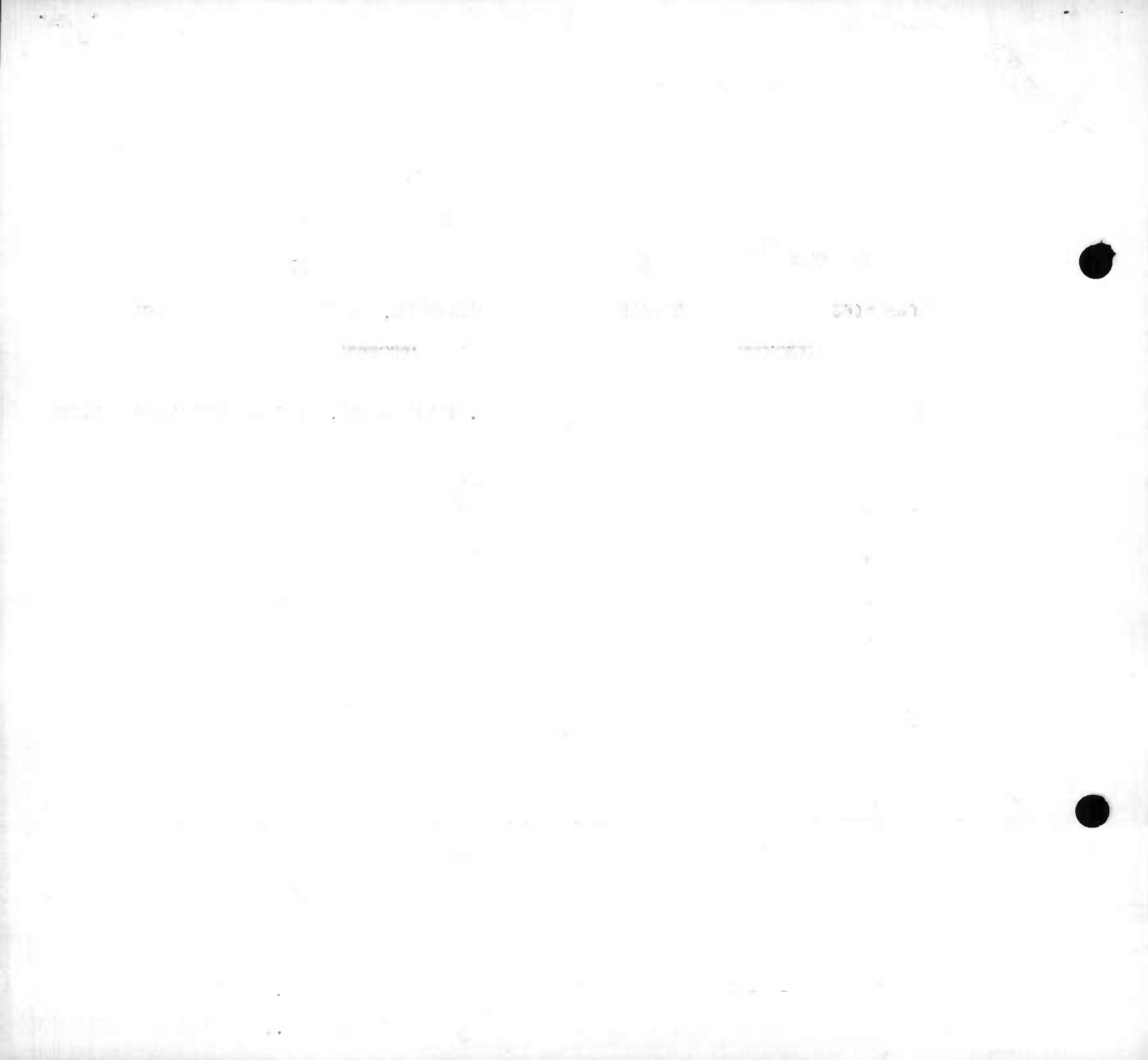
| | | | | | |
|--|--|---|--|--|--|
| F-523 71 0958 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0958 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>FEINSTEIN, MARICE</u> | | 2. DATE AND HOUR OF DEATH <u>1-26-71 7:55 PM</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u> | | M. <u>5300</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>2 Sinai</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>3-10-05</u> 9. AGE (in years last birthday) <u>65</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL GROCER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL GROCER</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>GERSON FEINSTEIN</u> | | 14. MOTHER'S MAIDEN NAME <u>REBECCA ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-14-5631A</u> | | 17. INFORMANT ADDRESS <u>MRS. ANNE FEINSTEIN, 2824 MARNAT RD. #21209</u> | |
| 18. I <u>410-91</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> | | <u>Hours -</u> | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>HSCVD</u> | | <u>Years -</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | _____ | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | <u>CVA</u> | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (we) (this hospital) attended the deceased from <u>25 JAN 19 71</u> to <u>26 JAN 19 71</u> that (we) last saw the deceased alive on <u>26 JAN 19 71</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Morris Ostroff</u> | | 23B. DATE SIGNED <u>1/26/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>MORRIS OSTROFF, MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-28-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u> | |
| 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS.</u> | | 25D. ADDRESS <u>6010 REISTERSTOWN ROAD</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0959 | |
|--|-------------------------|---|---|--|--|
| <div style="display: flex; justify-content: space-between;"> B-530 71 0959 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>BONDY, BERTHA</u> | | 2. DATE AND HOUR OF DEATH <u>27th Jan 1971</u> <u>1:15 P.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE INC.</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>7622 Carla Rd. #09</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>77</u> | 9. AGE (In years last birthday) <u>77</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>MR. IRVIN BONDY, 3302 LUDGATE ROAD #21215</u> | |
| 18. CAUSE OF DEATH | | | | | |
| I <u>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE PULMONARY EDEMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>MYOCARDIAL INFARCTION</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>About 8 hrs</u> <u>5 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>27th Jan. 1971</u> to <u>27th Jan 1971</u> that (I) (we) last saw the deceased alive on <u>27th Jan 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>P. PRASAD</u> <u>MBBS</u> DEGREE | | | | 23B. DATE SIGNED <u>27th Jan 1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>P. PRASAD</u> <u>MBBS</u> DEGREE | | | | 23D. ADDRESS <u>Sinai Hospital, Belvedere Ave., Balto., Md 21215.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-28-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u> | |
| 24D. LOCATION <u>BALTIMORE, MARYLAND</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 24F. NAME OF REGISTRAR <u>Robert E. Fisher, Md.</u> | |
| 24G. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 24H. NAME OF REGISTRAR <u>Robert E. Fisher, Md.</u> | | 24I. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | |



| 71 0960 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0960 | |
|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) JULIUS GLASSMAN | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 26 1971 12:40 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15 13 | | | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX male | | 7. RACE white | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH APRIL 12, 1900 | | 10. AGE (In years lost birthday) 70 | | E. STREET AND NUMBER 3000 W. Cold Spring Lane | |
| 11. BIRTHPLACE (State or foreign country) ROCHESTER, N. Y. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME NATHAN GLASSMAN | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 14B. KIND OF BUSINESS OR INDUSTRY GUARD WALTERS ART GALLERY | | 15. MOTHER'S MAIDEN NAME NATHAN GLASSMAN | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 133-03-3279 | | 18. INFORMANT ADDRESS MR. MARVIN J. LAND, 919 BLAUSTEIN BLDG. #1 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-27-71 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1-28-71 | | 24C. NAME OF CEMETERY or CREMATORY BETH JACOB VECAIR | |
| 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

ACADEMY JOURNAL

1914-1915

WALTER PAPER CO

1914-1915

1914-1915

1914-1915

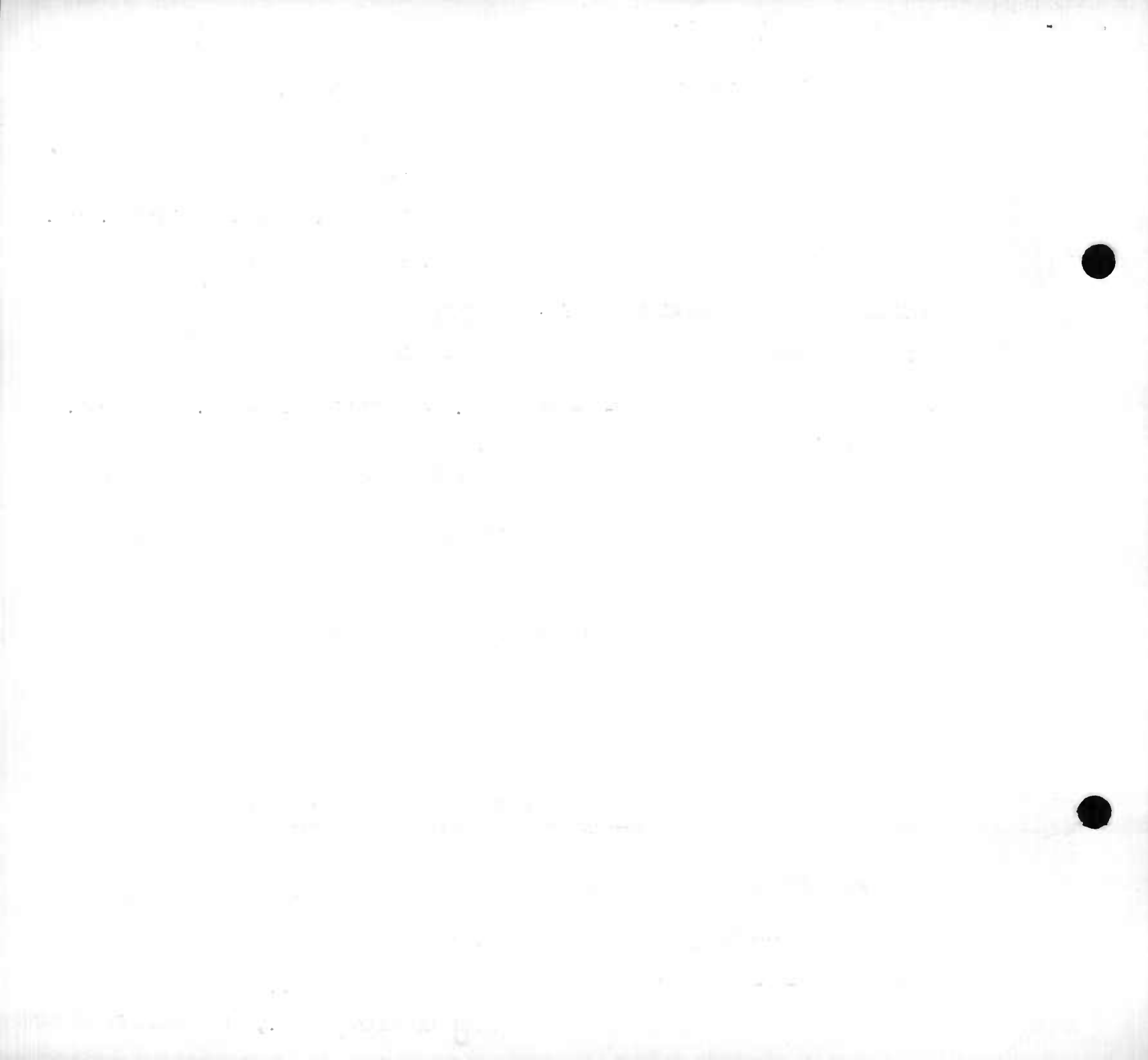
1914-1915

1914-1915

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|--|--|---|--|--|--|--|
| 71 0961 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0961 | | | | |
| BIRTH NO. <u>G-616</u> | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>NATHAN GRUBER</u> | | | | | 2. DATE AND HOUR OF DEATH <u>January 28, 1971</u> <u>7:20 P. M.</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>91 LEVINDALE</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | A. STATE <u>MARYLAND</u> | | | | |
| | | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER <u>HAMPSHIRE HOUSE, MENLO & PARK HIGHTS. AVE.</u> | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JULY 16, 1884</u> | 9. AGE (in years last birthday) <u>86</u> | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>GROCERY BUSINESS</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>SIMON GRUBER</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>BESSIE ?</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>216-24-8446</u> | | 17. INFORMANT ADDRESS <u>MRS. HARRY FEINBERG, 2410 W. ROGERS AVE. #9</u> | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Probable</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Cholelithiasis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cholelithiasis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | <u>years</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>Jan. 7</u> 19 <u>71</u> to <u>Jan. 28</u> 19 <u>71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>January 28</u> 19 <u>71</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(X)</u> view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Elsa R. Merani M.D.</u> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>Jan. 29, 1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ELSA R. MERANI, M.D.</u> | | | | | 23D. ADDRESS <u>Levindale</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>1-29-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>SHAAREI ZION</u> | | 24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

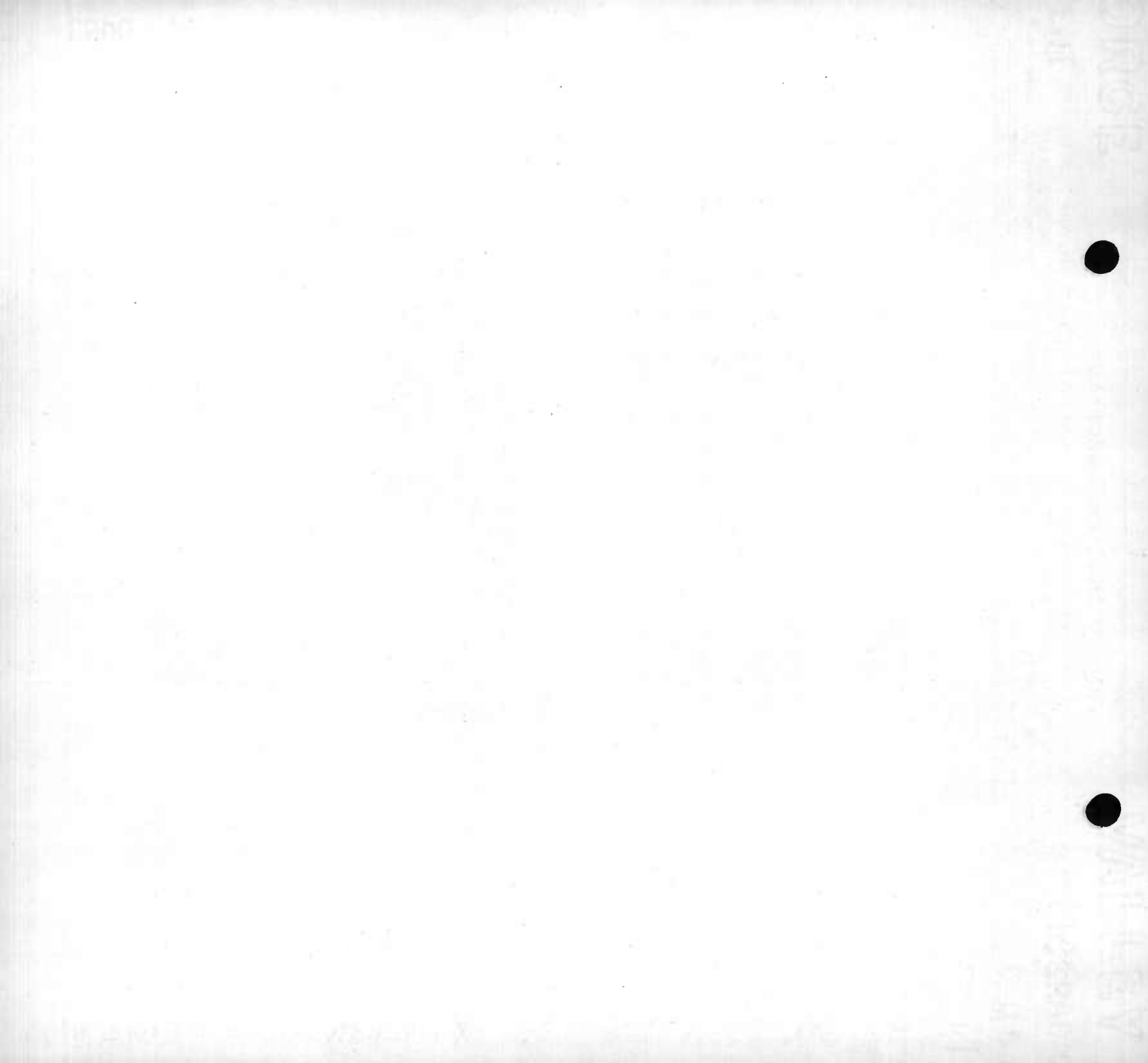
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 0962</u> | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. <u>S-160</u> | | 71 0962 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>SHAFFER, EVELYN IRENE</u> | | | 2. DATE AND HOUR OF DEATH <u>JANUARY 25, 1971</u> <u>10:45A</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1902</u> | | |
| | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>1435 W LOMBARD ST 21223</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>08/20/11</u> | 9. AGE (In years last birthday) <u>58</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>WARS VETERAN FOREIGN</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>GEORGE JOHNSON</u> | | | 14. MOTHER'S MAIDEN NAME <u>EDNA (CUDDY) JOHNSON</u> | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u> | | 16. SOCIAL SECURITY NO. <u>220-16-0546</u> | | 17. INFORMANT <u>ST. AGNES HOSPITAL RECORDS</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) <u>Terminal Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Severe Electrolyte Imbalance</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Polyglanular Thiazide</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PAB. @ Adrenal gland tumor</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 mons.</u> <u>2 mons.</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>no</u> | | | | | |
| 19A. DATE OF OPERATION <u>2/10</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 3</u> 19 <u>71</u> to <u>JANUARY 25</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>JANUARY 25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Carleann Malaisrie</u> | | | | 23B. DATE SIGNED <u>Jan 26, 1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>SUNTHORN MALAISRIE</u> | | 23D. ADDRESS <u>BALTIMORE, MARYLAND 21229</u> <u>ST. AGNES HOSPITAL; CATON & WILKENS AVES</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-29-1971</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Frederick, Frederick, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Dailey</u> | | 25C. FUNERAL DIRECTOR <u>Robert E. Dailey & Son Funeral Home Fred.Md.</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0963 |
|---|--------------------------------|---|--|---|
| BIRTH NO. M-620 | | 71 0963 CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) SOPHIA A. MORAWSKI | | | 2. DATE AND HOUR OF DEATH JAN. 28, 1971 10:00 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 524 S. POTOMAC ST. BALTO., MD. 21224 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 102 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 524 S. POTOMAC ST. | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 13, 1891 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS | | 10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL | | 9. AGE (In years last birthday) 79 If Under 1 Yr. Months: Days: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) POLAND. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME BRONISLAW RUPINSKI | | | 14. MOTHER'S MAIDEN NAME ROSALIA KLEMKOWSKI | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214-16-6988 | | 17. INFORMANT John Morawski - 524 S. POTOMAC ST. |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE UREMIA DUE TO, OR AS A CONSEQUENCE OF: (B) CARCINOMA of the Ovary DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | |
| 19A. DATE OF OPERATION 0 | | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19__ to 19__, that (I) (we) last saw the deceased alive on 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Frank W. Baker, MD | | | | 23B. DATE SIGNED 1-30-71 |
| 23C. PHYSICIAN'S NAME (Type) FRANK W. BAKER M.D. | | | | 23D. ADDRESS 2529 EASTERN AVE. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/1/71 | | |
| 24C. NAME of CEMETERY or CREMATORY HOLY ROSARY CEM. | | 24D. LOCATION (City, town, or county) (State) BALTO. CO., MD. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR W. FIALKOWSKI | | |
| 25C. FUNERAL DIRECTOR W. FIALKOWSKI | | ADDRESS 2007 EASTERN AVE | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0964 | |
|--|--|--|--|---|--|
| BIRTH NO. W-630 | | 1. NAME OF DECEASED (Type or Print) Worthy, Roosevelt | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 HILTON NURSING HOME 3313 Poplar Street | | 2. DATE AND HOUR OF DEATH January 29, 1971 8:45 A.M. M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1001 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1301 E. Chase Street | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 07-04-07 9. AGE (In years last birthday) 63 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY CONTRACTORS | | 11. BIRTHPLACE (State or foreign country) S. C. | |
| 13. FATHER'S NAME Banks Worthy | | 14. MOTHER'S MAIDEN NAME Eliza | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 216-10-3953 | | 17. INFORMANT Andrew SANDERS ADDRESS 1301 E. Chase St | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pulmonary emphysema Chronic bronchitis ANTECEDENT CAUSES Respiratory insufficiency </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). A. S. C. V. D. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the doctor) attended the deceased from June 19, 19 70 to January 29, 19 71 that (I) (yes) last saw the deceased alive on January 26, 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (the doctor) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Barbu Calin | | | | 23B. DATE SIGNED 1-29-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Barbu Calin | | | | 23D. ADDRESS 831 Poplar Grove Street, Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary | |
| 24D. LOCATION (City, town, or county) A.A. County, Md. | | 24E. STATE | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | |
| 25B. NAME OF REGISTRAR Blair E. Fisher, Md. | | 25C. FUNERAL DIRECTOR Joseph J. Locks | | 25D. ADDRESS 1304 N. Center St | |

Robertson
Charles Robertson
Robertson
Robertson

A. C. V. D.

1-28-1

Robertson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0965 | |
|---|--|---|--|--|--|
| BIRTH NO. G-635 | | 1 0965 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) CATHERINE GARDNER | | | 2. DATE AND HOUR OF DEATH 10 AM 1/26/71 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 10-3 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME + HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 2424 FOSTER AVE | | | |
| 5. SEX F | 6. RACE (AUC) White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-26-92 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME ANTON KIPUTSCH | | 14. MOTHER'S MAIDEN NAME ANNA WICK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 21805322 | | 17. INFORMANT CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 174 X I | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHO PNEUMONIA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | (B) DUE TO, OR AS A CONSEQUENCE OF: BREAST CANCER embolusis to the thorax. | | 2 yrs | |
| | | (C) PYO THORAX | | 15 days | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6 1970 to 1/26 1971 that (I) (we) last saw the deceased alive on 1/26 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A.C. Chouvalit, M.D. | | | | 23B. DATE SIGNED 1/26/71 | |
| 23C. PHYSICIAN'S NAME (Type) A.C. CHOUVALIT, M.D. | | | | 23D. ADDRESS Church Home of Hospital Balto, Md 21231 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 1/30/71 | | 24C. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Vabey | | 25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI | | | |
| ADDRESS 2525 FLEET ST. | | | | | |



71 0966 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) Anna B. Wyrobek

2. DATE AND HOUR OF DEATH

11:45 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

806 South Milton Avenue 21224

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

10-3-04

9. AGE (in years last birthday)

66

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph TRUSCHKA

14. MOTHER'S MAIDEN NAME

Augusta Sotki

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: Records Baltimore, Maryland 21224

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

LIVER ARREST & PERITONITIS

(C)

DIABETES MELLITUS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

31/19/71

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Peritonitis

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/18 19 71 to 1/27 19 71 that (I) (we) last saw the deceased alive on 1/27 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

F. Nahai

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

1/28/71

23C. PHYSICIAN'S NAME (Type)

F. Nahai

M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/30/71

24C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore MD.

25A. DATE RECD BY HEALTH DEPT

FEB 1 1971

25B. NAME OF REGISTRAR

Robert E. Fabelo

25C. FUNERAL DIRECTOR

RAYMOND L. KACZOROWSKI 2525 Fleet St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

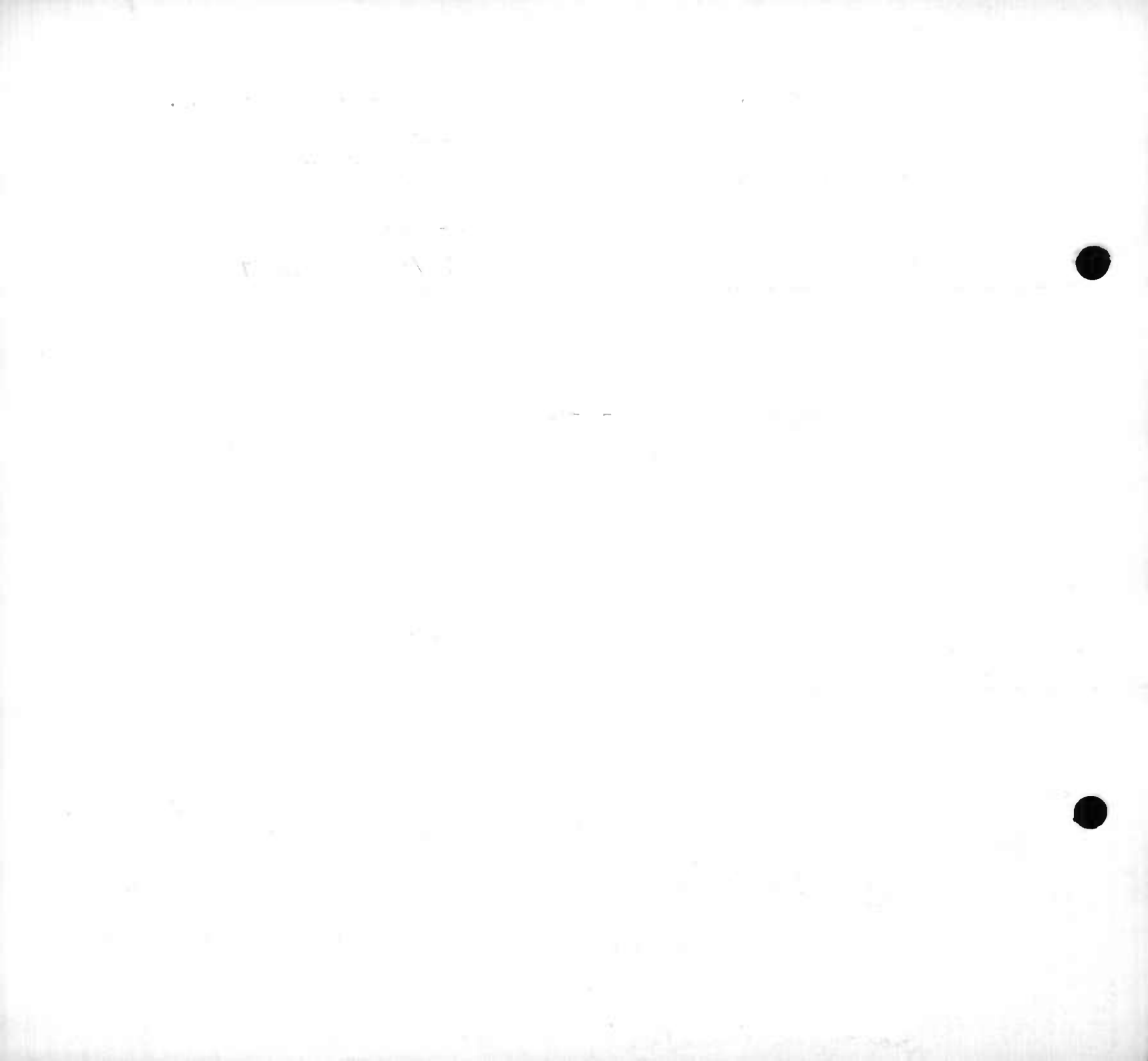
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

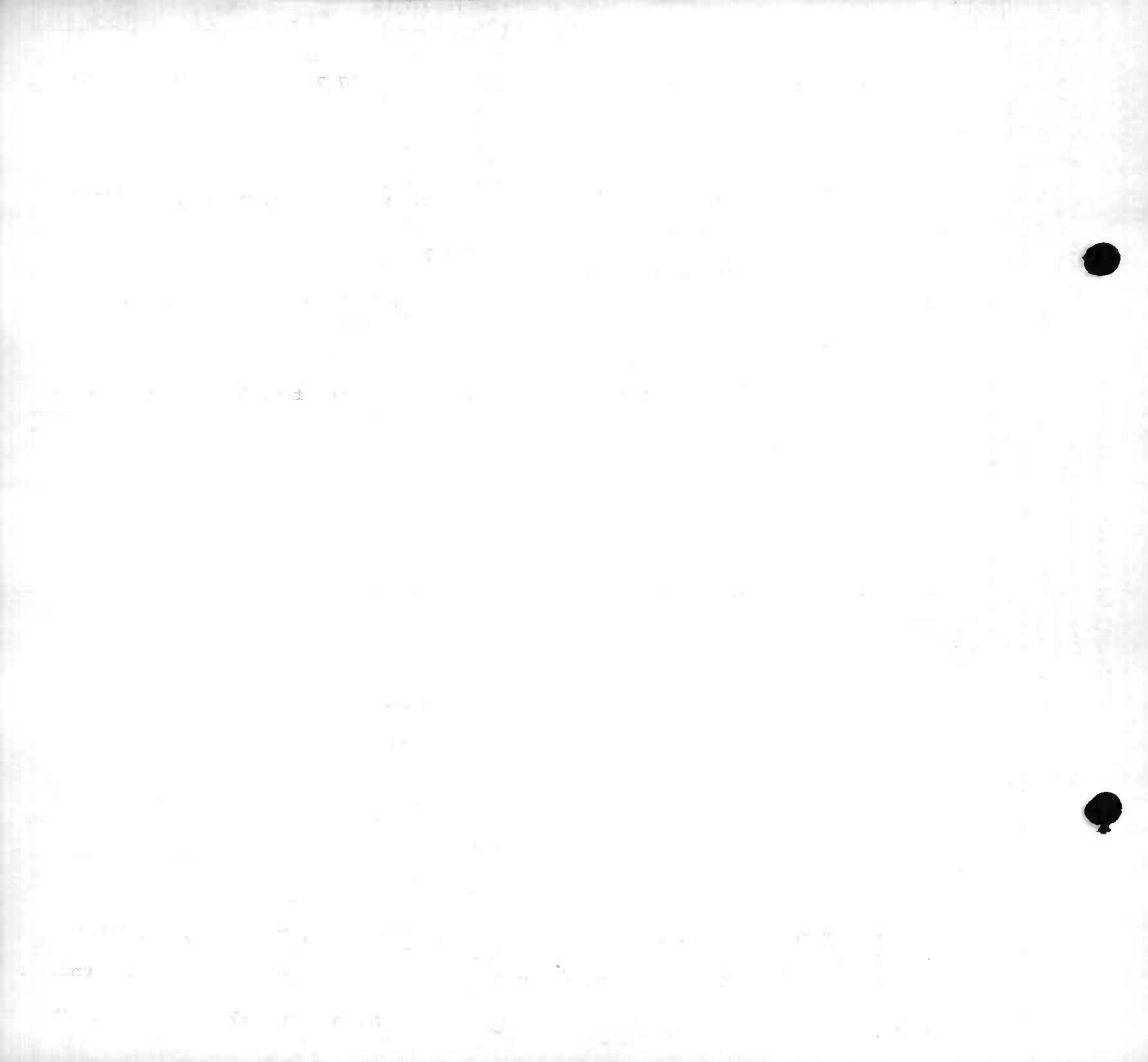
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0967 | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 71 0967 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Gardner, Lester | | | 2. DATE AND HOUR OF DEATH 1-27-71 10:30 p.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hilton Nursing Home | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2864 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4307 Adelle Terrace | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/1/83 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 218-36-2380 | | 17. INFORMANT ADDRESS | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) A. S. C. V. D. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | Pneumonia | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-15-1970 to 1-27-1971 that (I) (we) last saw the deceased alive on 1-26-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Barbu Calin | | | 23B. DATE SIGNED 1-28-71 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) BARBU CALIN | | | 23D. ADDRESS 831 Poplar Grove | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 1-28-71 | | 24C. NAME OF CEMETERY or CREMATORY UNIV. MED. SCHOOL NAT. BD. OF MD. | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. | | 25A. DATE RECEIVED BY HEALTH DEPT. FEB 1 1971 | | | |
| 25B. NAME OF REGISTRAR PROFESSIONAL, M.S. BALTO. Md. | | 25C. FUNERAL DIRECTOR ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. | | 71 0968 | | CERTIFICATE OF DEATH | | REG. NO. 71 0968 | |
|---|---------------------|---|-----------------------------------|--|--|---|---|---|--|------------------|--|
| 1. NAME OF DECEASED (Type or Print) GERALDINE DOUGHERTY | | | | 2. DATE AND HOUR OF DEATH 1/27/71 6:20p.m. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 2712 | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Baltimore, Md. | | | | C. CITY OR TOWN BALTIMORE | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER 103 St. Dunstons Rd., Balto., Md. 21212 | | | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/2/17 | 9. AGE (In years last birthday) 53 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME Lee Falkenstein | | | | 14. MOTHER'S MAIDEN NAME Emma Krebs | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 212-05-1969 | | | | 17. INFORMANT ADDRESS Mr. Patrick Dougherty, 103 St. Dunstons Rd. | | | |
| 18. 371.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gastrointestinal bleeding | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cirrhosis of liver | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-26-71 to 1-27-71 that (I) (we) last saw the deceased alive on 1-27-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Thanasophon M.D. | | | | 23B. DATE SIGNED 1/27/71 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Suriyan Thanasophon, M.D. | | | | 23D. ADDRESS 301 St. Paul Place, Baltimore, Md. 21202 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/30/71 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Cemetry | | 24D. LOCATION (City, town, or county) (State) Cockeysville, Balto. County Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Raymond J. Curran | | 25C. FUNERAL DIRECTOR 817 Scarlett Dr., Towson Md. | | ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

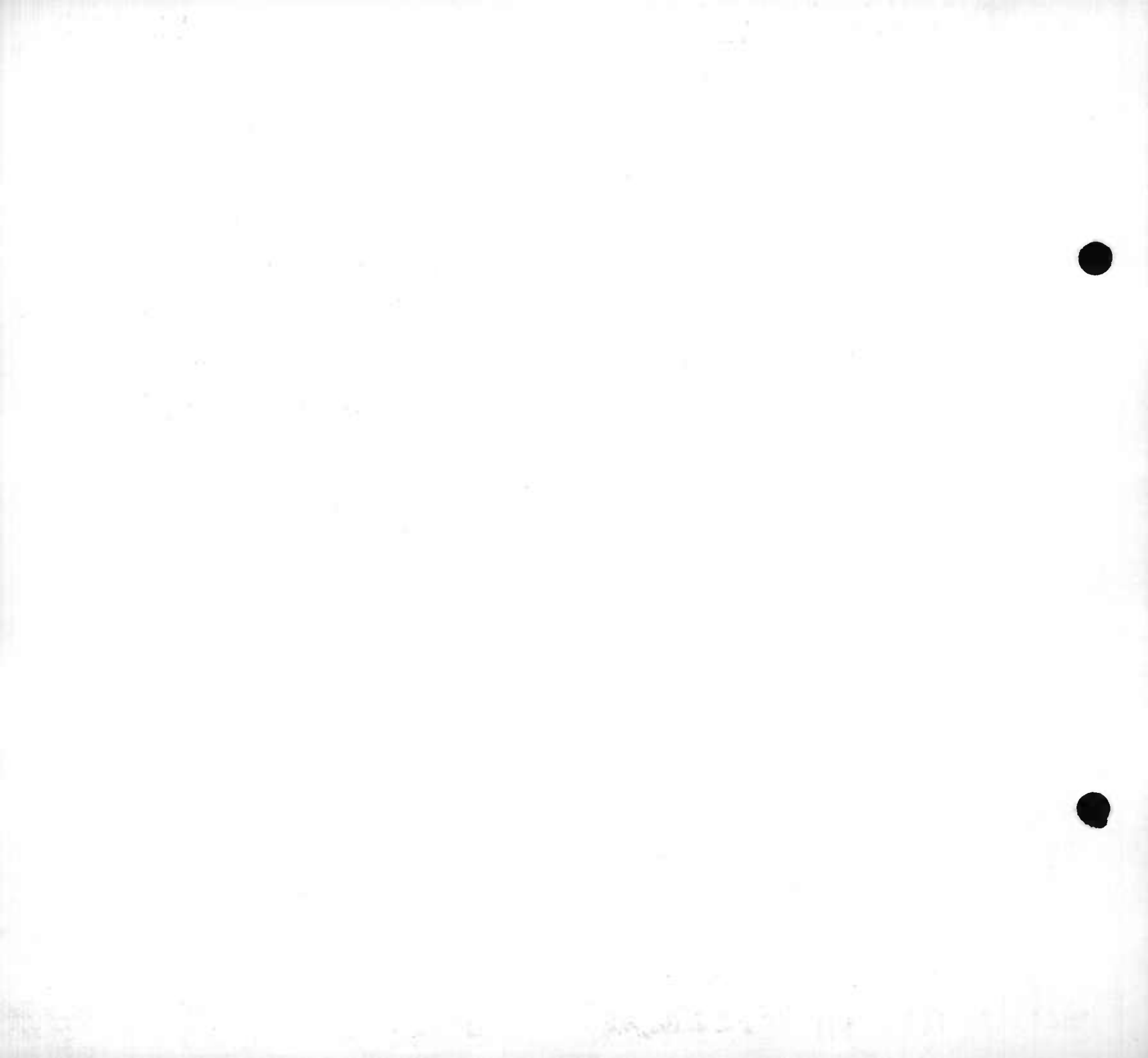
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 0969</u> |
|---|--|---|--|---|
| BIRTH NO. <u>71 0969</u> | | 1. NAME OF DECEASED (Type or Print) <u>Rosa Kramer (ROSA KRAMER)</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH <u>1/28/71</u> <u>1:54</u> <u>PM</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Pleasant Manor Nursing Home</u> <u>4615 Park Heights Ave</u> <u>Baltimore 21215 Md</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>902</u> | | |
| 5. SEX <u>Female</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <u>5/22/88</u> | | 9. AGE (In years last birthday) <u>88</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Frederick Sigmund Baum</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Tvenian</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | |
| 16. SOCIAL SECURITY NO. <u>218-52-1315</u> | | 17. INFORMANT <u>H. Andrew Jones</u> <u>1532 Calworth Rd</u> <u>Balto. Md.</u> | | |
| 18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Brucellosis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> <u>2 years</u> | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: <u>7 Mononucleosis</u> <u>4 weeks</u> | | (C) <u>None</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> 19 <u>70</u> to <u>Jan 28</u> 19 <u>71</u> that (I) <u>we</u> last saw the deceased alive on <u>Jan 28</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death. | | | | |
| 23A. SIGNATURE <u>Manuel Levin MD</u> | | 23B. DATE SIGNED <u>Jan 28/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN M.D.</u> |
| 23D. ADDRESS <u>6161 PARK HTS AVE</u> <u>BALTO MD 21215</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>Jan. 30. 1971</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Rose E. Jones, MD.</u> | | 25C. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> <u>Baltimore Md.</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

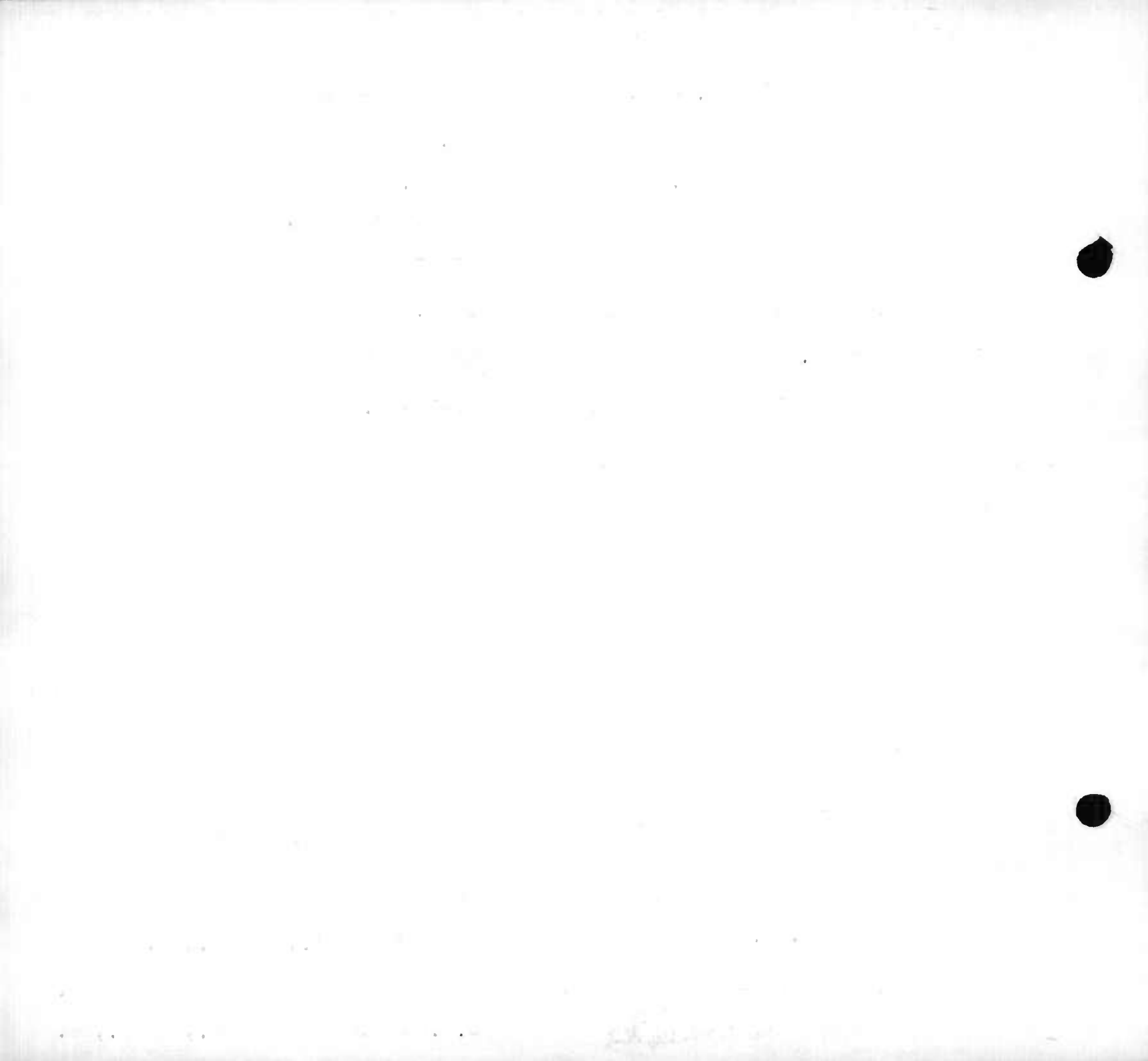
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 71 0970 CERTIFICATE OF DEATH | | | | | REG. NO. 71 0970 | | | | |
| BIRTH NO. <u>H-460</u> | | | | | 1. NAME OF DECEASED (Type or Print) <u>HELLER, MILDRED A.</u> | | | | |
| 2. DATE AND HOUR OF DEATH <u>1/31/1971 2:02AM.</u> | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MARYLAND GENERAL HOSPITAL</u> | | | | | A. STATE <u>MD.</u> B. COUNTY <u>Baltimore City</u> | | | | |
| | | | | | C. CITY OR TOWN <u>City - Balto.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER <u>3720 Greenmount Ave #18.</u> | | | | |
| 5. SEX <u>Female</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-13-1912</u> | | 9. AGE (in years last birthday) <u>58 Yrs.</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECT - Clerk.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>retired Benefit Corp</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>ORVILLE K. HELLER</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>ALMA M. BENNY</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. <u>212-05-9735</u> | | 17. INFORMANT <u>MRS. RUTH H. BROEL</u> ADDRESS <u>139 HARRIS ST. MIDDLESEX N.J. 08846</u> | | |
| 18. <u>412.21</u> CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | <u>Cerebral edema</u> | | | | |
| I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) IMMEDIATE CAUSE <u>Stroke</u> | | | | |
| ANTECEDENT CAUSES | | | | | DUE TO, OR AS A CONSEQUENCE OF: <u>Indurated Hemorrhage</u> | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) <u>Indurated Hemorrhage</u> | | | | |
| | | | | | (C) <u>Hypertension Hypertension</u> | | | | |
| II | | | | | <u>cardiovascular disease</u> | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/28/1971</u> to <u>1/31/1971</u> that (I) (we) last saw the deceased alive on <u>1/31/1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>M. S. Al-Brahim M.D.</u> | | | | | 23B. DATE SIGNED | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>M. S. AL-BRAHIM</u> | | | | | 23D. ADDRESS <u>Maryland General Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>2-3-1971</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u> | | 25C. FUNERAL DIRECTOR <u>Henry W. Jenkins</u> | | ADDRESS <u>4905 York Rd 21212</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------------------|--|--|---|--|
| G-645 71 0971 | | | | 71 0971 | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Charles S. Garland</u> | | | | 1-28-71 11:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4 Charlcote Rd.</u> | | | | A. STATE <u>Md.</u> B. COUNTY <u>2711</u> | |
| | | | | C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>4 Charlcote Rd.</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-28-1898</u> | 9. AGE (in years last birthday) <u>72</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investment Banker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Investments</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Charles S. Garland</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lillie Chisholm</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW 1</u> | | 16. SOCIAL SECURITY NO. <u>320-01-3873</u> | | 17. INFORMANT <u>Aurelia S. Garland</u> | |
| | | | | ADDRESS <u>Same</u> | |
| 18. <u>412.4 I</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? <u>clinical diagnosis - Confined</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct 1953</u> to <u>Jan 29th 1971</u> that (I) (we) last saw the deceased alive on <u>Jan 29th 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W. H. Woody MD</u> | | | | 23B. DATE SIGNED <u>1-30th 71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>W. H. Woody MD</u> | | | | 23D. ADDRESS <u>1403 Park Ave., Balto., Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>1-30-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR <u>B. W. Jenkins & Sons Co., Bal to., Md.</u> | |

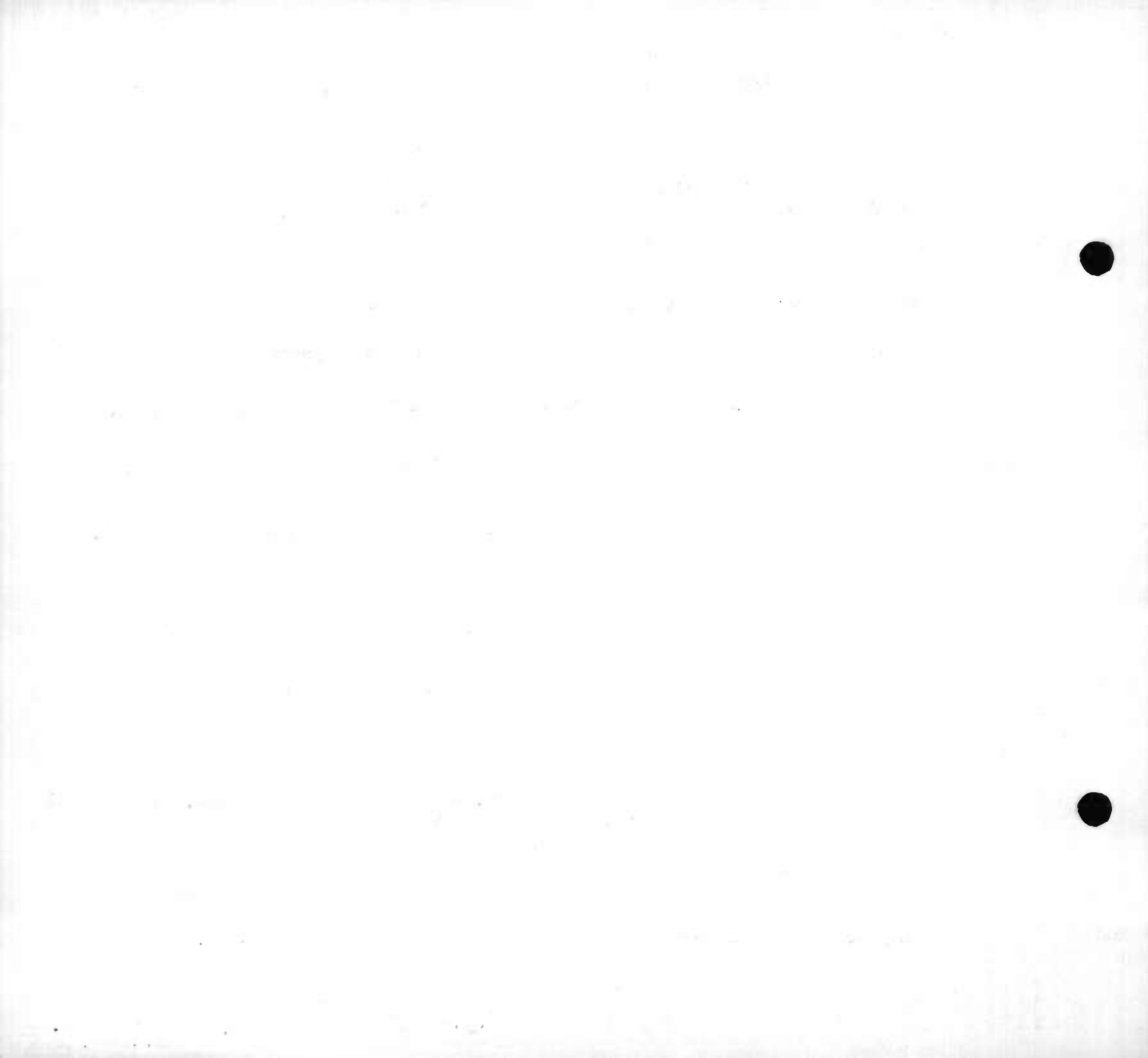


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 71 0972 | | | | | | | | | |
| BIRTH NO. <u>K-400</u> | | 71 0972 | | 1. NAME OF DECEASED (Type or Print) <u>Michael Vincent Kelly</u> | | | 2. DATE AND HOUR OF DEATH <u>Jan. 28, 1971</u> <u>6: 05</u> P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>US Public Health Service Hospital</u> <u>3100 Wyman Parkway</u> | | | | A. STATE <u>NJ</u> | | B. COUNTY <u>V-27</u> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN <u>Pine Hill</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER <u>1069 Brace Rd.</u> | | | | | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2/12/27</u> | 9. AGE (in years last birthday) <u>43</u> | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deck Maintenance</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Seafarer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Paul V. Kelly</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Georgette Renee</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>USA 1950-1952</u> | | 16. SOCIAL SECURITY NO. <u>170-20-5661</u> | | 17. INFORMANT <u>Records- US PHS Hospital, Balto, Md.</u> | | | | | |
| 18. <u>199.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic adenocarcinoma</u> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) <u>Metastatic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>8 mos.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pulmonary embolus & infarct</u> | | | | | | Weeks | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.) 1 Month 1 Day 1 Year 1 Hour | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5</u> 19 <u>70</u> to <u>Jan. 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Jan. 28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Gary E. Feldman, M.D.</u> | | | | 23B. DATE SIGNED <u>1/29/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Gary E. Feldman, Surg (R)</u> | | | |
| 23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal-Burial</u> | | 24B. DATE <u>2/2/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Berlin</u> | | 24D. LOCATION <u>Berlin</u> | | 24E. CITY, town, or county (State) <u>New Jersey</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Sabers, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>H. G. Jenkins & Sons Co.</u> | | 25D. ADDRESS <u>4905 York Rd. Balto., Md. 21212</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0973 | | 71 0973 | |
|---|---------------------|---|--|---|--|---|------------------|
| BIRTH NO. <u>H-125</u> | | | | 71 0973 | | 71 0973 | |
| 1. NAME OF DECEASED (Type or Print) <u>MARY R. HOPKINS</u> | | | | 2. DATE AND HOUR OF DEATH <u>1/30/71</u> <u>5:45 P. M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Md.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2714</u> | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>4608 ROLAND AVE.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-06-93</u> | 9. AGE (In years last birthday) <u>77</u> | 10. Under 1 Month | 11. Under 1 Year |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SECRETARY</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>LAW OFFICE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | 13. FATHER'S NAME <u>JOHN T. HOPKINS</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>FRANCES POLLARD</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>220-24-0494</u> | | | | 17. INFORMANT <u>MISS ELLAINE HOPKINS (SAME)</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTICAEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA + URINARY INFECTION.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>OSTEOARTHRITIS SPINE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>SENILITY</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>1/30/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>1/30/71</u> to <u>1/30/71</u> 19 <u>71</u> and that (H) (we) lost saw the deceased alive on <u>1/30/71</u> 19 <u>71</u> and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>S. BASU</u> | | | | 23B. DATE SIGNED <u>1/30/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u> | |
| 23D. ADDRESS <u>Lutheran Hospital of Maryland</u> | | | | 23E. DEGREE <u>MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2-3-1971</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> | | ADDRESS <u>4905 York Road Balto., Md. 21212</u> | |

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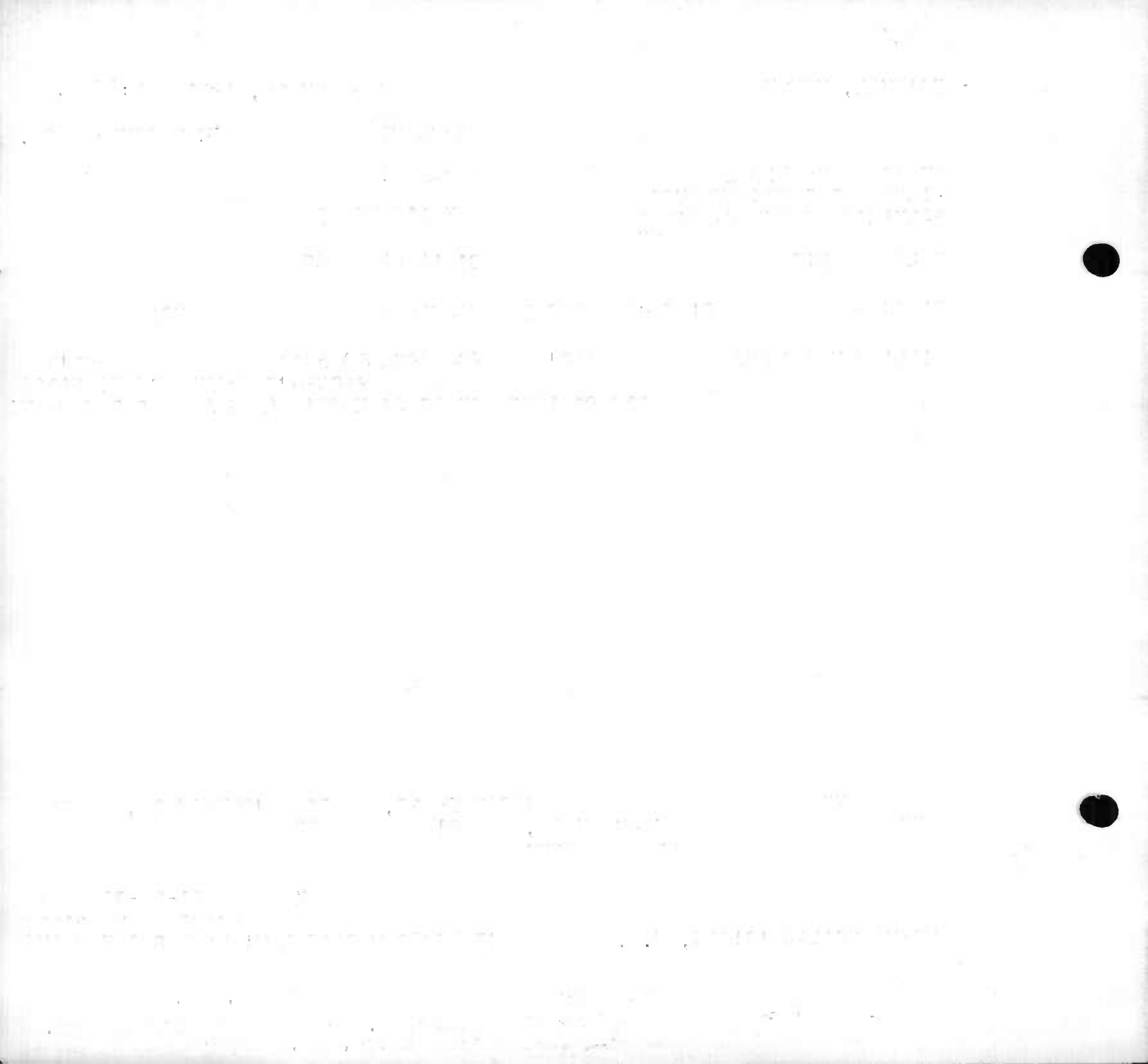
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0974 | | 71 0974 | |
|--|--|--|--|---|--|---|--|
| T-614 | | | | 71 0974 | | 71 0974 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | TRIBULL, HENRY | | JANUARY 29, 1971 2:45 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | MARYLAND | | 8. COUNTY | |
| ST AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE MARYLAND 21229 | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | PASADENA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| MALE | | | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| FIREMAN | | | | FIRE DEPARTMENT | | 01 14 04 | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| WILLIAM V TRIBULL | | | | DEC 'D | | 67 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) | |
| NO | | | | 220 05 1820 | | MARYLAND | |
| 17. INFORMANT | | | | RECORD'S BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | ST AGNES HOSPITAL WILKENS & CATON AVE | | USA | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | Chronic Obstructive Lung Disease | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| Jan - 11, 1971 | | Ca Hepatic Flexure | | NO NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 23, 1970 to JANUARY 29, 1971 that (X) (we) last saw the deceased alive on JANUARY 29, 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (X) (view the body after death). | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| HERMENEGILDO ISIDRO, M.D. | | | | Jan-29-71, 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| BALTIMORE MD 21229 | | | | ST AGNES HOSPITAL WILKENS & CATON AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2/1/71 | | Holy Cross | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 1 1971 | | Robert E. Talley, Jr. | | George J. Gonce | | 4001 Ritchie Hgy. Baltimore, Md. 21225 | |



S-450

71 0975

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 0975

BIRTH NO.

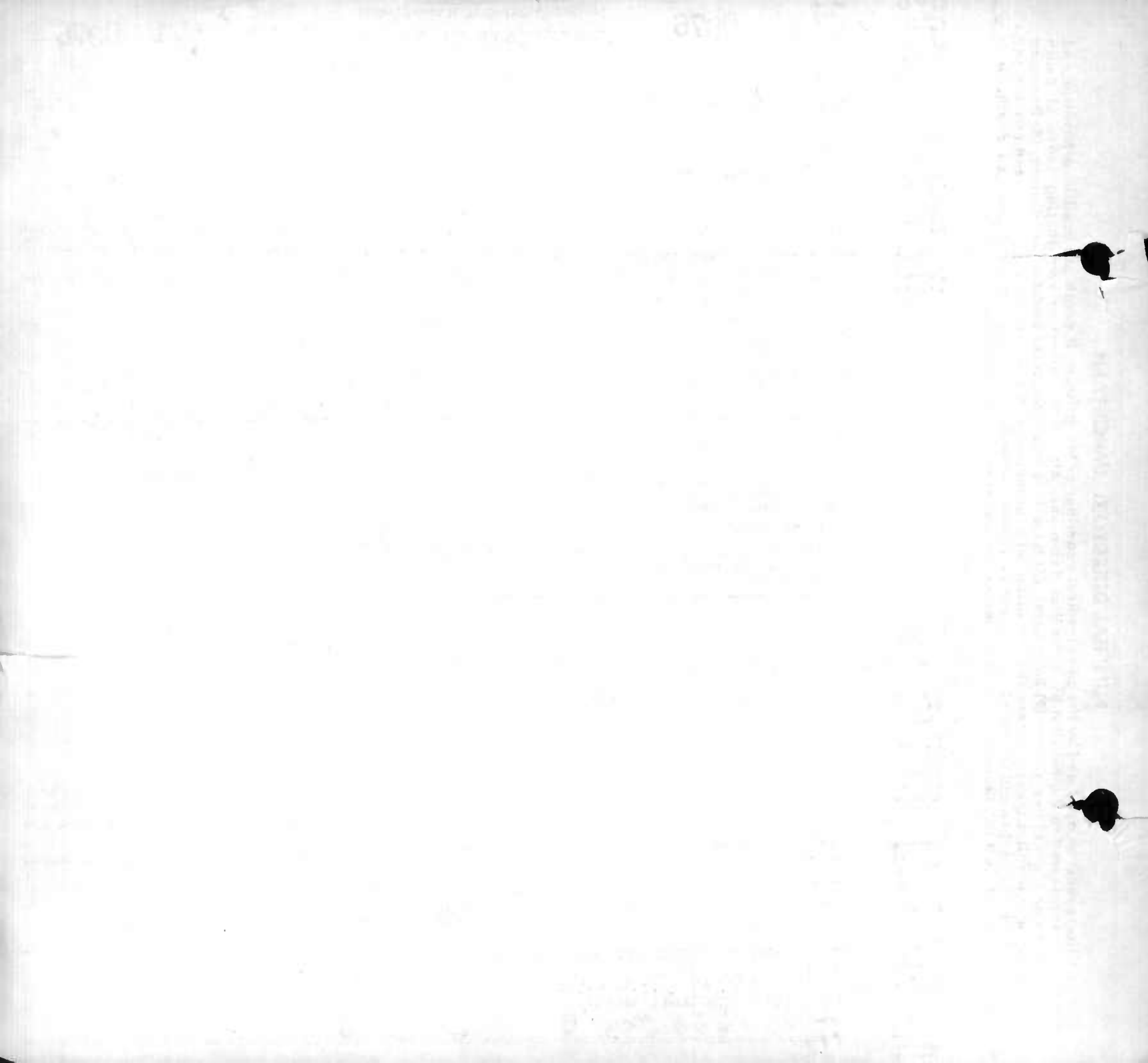
| | | | | | | | |
|---|--|---|---|--|---------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) MARGARET SLOAN | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospital | | 3. DATE PRONOUNCED DEAD | | Month | Day | Year | Hour |
| | | | | 1 | 26 | 1971 | 2:40 p.m. |
| 6. SEX female | | 7. RACE white | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH 28 Dec 1917 | | 10. AGE (In years lost birthday) 54 | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 220-249444 | | 18. INFORMANT WILLIAM SLOAN, 7608 DUNMAY WAY | | ADDRESS 21222 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE Aspiration of bolus of food DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 7608 Dunmay Way 5300 | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 1-26-71 1:20 p.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Choked on food while eating. | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-27-71 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 30 JAN 71 | | 24C. NAME OF CEMETERY or CREMATORY MEADOW RIDGE MEMORIAL | | 24D. LOCATION (City, town, or county) (State) HOWARD Co., MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR CLERIGA FUNERAL HOMES, DUNDALK, MD | | ADDRESS | |

7608 Dunmanway

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| N-650 71 0976 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 71 0976 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>VERYAN, Matthew Everett</i> | | 2. DATE AND HOUR OF DEATH <i>1-26-1981 11 35 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | 5. CITY OR TOWN <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>M</i> | | 6. RACE <i>W</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Westinghouse employer (Retired).</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <i>12-26-03</i> | |
| 13. FATHER'S NAME <i>Matthew (Dee)</i> | | 14. MOTHER'S MAIDEN NAME <i>Carolyn (Dee)</i> | | 9. AGE (in years last birthday) <i>67</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | |
| 17. INFORMANT <i>Mr. J. Neryan, 7438 Berkshire Rd.</i> | | ADDRESS <i>7438 Berkshire Rd.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>O.S.A.</i> | |
| 18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Antero-Scelerosis - Cardio-vascular Disease</i> (B) <i>Dehydration</i> (C) <i>Depression</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-26-81</i> 19 to <i>1-26</i> 19 <i>81</i> that (I) (we) last saw the deceased alive on <i>1-26</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>D. Cabriss</i> | | 23B. DATE SIGNED <i>1-26-81</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Dr. Cabriss</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>30 JAN 1</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN CEMETERY</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1981</i> | | 25B. NAME OF REGISTRAR <i>Robert J. ...</i> | | 25C. FUNERAL DIRECTOR <i>Charles ...</i> | |
| 26A. ADDRESS <i>...</i> | | 26B. ADDRESS <i>...</i> | | 26C. ADDRESS <i>...</i> | |



| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Marshall, Williams <i>Ronald</i> | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 30 71 4:30 a M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 1 30 71 4:30 a M. | |
| 6. SEX male | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 808 | |
| 7. RACE colored | | C. CITY OR TOWN Baltimore | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 9-19-1943 | | 10. AGE (In years last birthday) 27 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Frank Marshall | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | |
| 15. MOTHER'S MAIDEN NAME Estelle Barry | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Estelle Marshall-1706 Ashburton | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Narcotic addiction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 22A. DATE OF OPERATION | | 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22H. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 23A. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| 23B. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 23C. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23D. ACTUAL SIGNATURE Werner U. Spitz, M.D. | | 23E. DATE SIGNED 1/30/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-3-70 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Walter E. Ellington | | 25D. ADDRESS N. Caroline | |

3/5/71 - Letter from M.E. Office. *See*

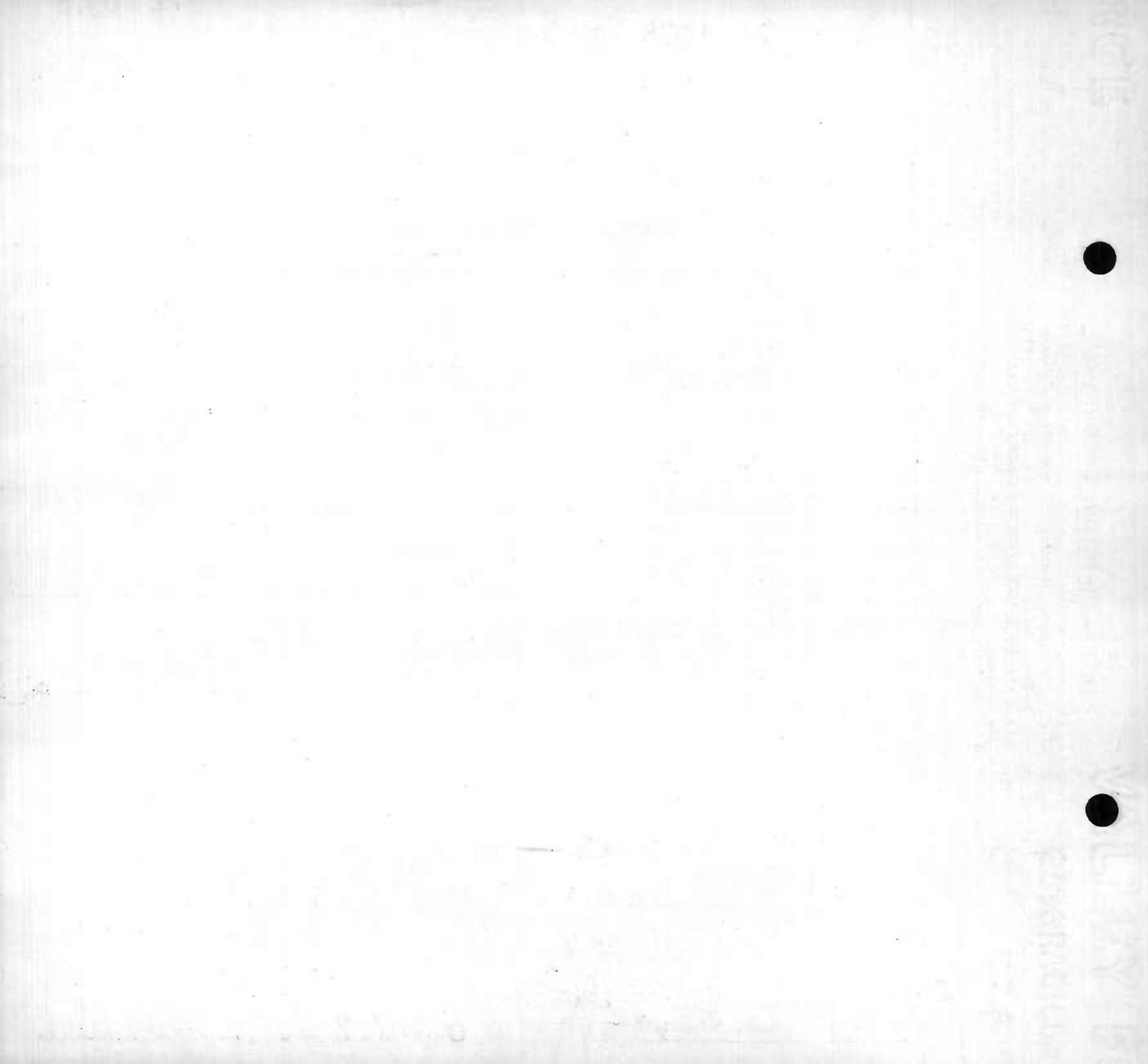
ACADEMY BUILDING

Faulkner, Wm.
26-63-76

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0978 | | 71 0978 | |
|---|-------------------------|---|-------------------------------------|--|---|---|---|
| F-425 | | | | 71 0978 | | 71 0978 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM FAULKNER | | | | 2. DATE AND HOUR OF DEATH 1/29/71 2:00 AM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 1903 KENNEDY AVENUE | | | | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-28-17 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Van | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JOHN FAULKNER | | | | 14. MOTHER'S MAIDEN NAME Katie Williams | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lemma Faulkner | | ADDRESS 1903 Kennedy Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4-10-91 Ventricular fibrillation (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction | | | | CAUSE OF DEATH Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/10 19 71 to 1/29 19 71 , that (I) last last saw the deceased alive on 1/29 19 71 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David J. Driscoll MD | | | | 23B. DATE SIGNED 1/29/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) David J. Driscoll MD | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-2-71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Shesport, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Robert E. Taylor, M.D. | | ADDRESS 12971 Culbert | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|---|
| C-636 71 0979 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0979 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Carter, Bessie | | 1-30-71 5:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| Mt. Sinai Nursing Home | | | Md 21205 | | |
| 4013 Park Heights Ave. | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX | | | E. STREET AND NUMBER | | |
| F | | | 1004 N. Edgewood St. | | |
| 6. RACE | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH |
| Blk. | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2-7-93 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 9. AGE (In years last birthday) |
| Retired - Domestic | | | Md. | | 78 |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| | | | U.S.A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Unknown | | | Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT |
| | | | | | Ms. Helma Key - 1004 N. Edgewood St. |
| 18. 437.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | | Aspiration pneumonia | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Cerebrovascular Accident | | |
| | | | (C) Arteriosclerotic Cerebrovascular Disease | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | Possible Hemolytic Anemia; Bladder Infection; Arteriosclerotic cardiovascular disease. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 28 1971 to January 30 1971 that (I) (we) last saw the deceased alive on January 29 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Henry J. Babitt, M.D. | | | | January 30, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| | | | | 4623 Hawksbury Rd, Balt., Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 1-4-71 | | Baltimore National Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 1 1971 | | Robert E. Babitt, M.D. | | Edith K. Howard Home 1129 N. Caroline St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-520 | | 71 0980 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 0980 | |
|---|---------------------|---|--|--|--|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Lehman GEORGE L TIMMS | | | | 2. DATE AND HOUR OF DEATH Jan 29th 1971 2:05 am M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 22-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles Gen. Hospital | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER Forest Haven Nursing Home | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/15/92 | 9. AGE (In years lost birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Sam TIMMS | | | | 14. MOTHER'S MAIDEN NAME MARY BODENFELK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-07-8332A | | 17. INFORMANT J. Papastephanou | | ADDRESS North Charles Hospital | |
| 18. CAUSE OF DEATH 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe dehydration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe dehydration (B) DUE TO, OR AS A CONSEQUENCE OF: Severe dehydration (C) C.V.H. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/28/71 19 to 1/29/71 19 that (I) (we) last saw the deceased alive on 1/29/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John C. Papastephanou, M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/29/71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. C. PAPASTEPHANOU | | | | 23D. ADDRESS North Charles Gen. Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 | | 25B. NAME OF REGISTRAR John C. Papastephanou | | 25C. FUNERAL DIRECTOR Schumnek Funeral Home, Inc. | | ADDRESS 3331 Brehms Lane | |

332 W. Camden St.

7/5/68 CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0981 | |
|--|--|--|--|---|--|
| T-264 71 0981 CERTIFICATE OF DEATH | | BIRTH NO. 71 0981 | | | |
| 1. NAME OF DECEASED (Type or Print) Joseph M. Tagaricillo | | | 2. DATE AND HOUR OF DEATH 1/30/71 8³⁵ A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2-02 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Friedley House 2449 Shirley Ave. 15 | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX Male | | | 6. RACE White | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 8/3/1898 | | |
| 9. AGE (In years last birthday) 72 | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. NAVY | | |
| 11. BIRTHPLACE (State or foreign country) Italy | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | | 16. SOCIAL SECURITY NO. 451-22-3610 | | |
| 17. INFORMANT Hosp. Chart | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 491X I Broncho pneumonia | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Spondylosis of cervical spine & spinal cord degeneration | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 4 years | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: Emphysema obstructive | | | 4 years | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: Chronic bronchitis | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 18</u> 19<u>69</u> to <u>Jan 30</u> 19<u>71</u>, that (I) (we) last saw the deceased alive on <u>Jan 30</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel Levin MD | | | | 23B. DATE SIGNED 1/30/71 | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN MD | | | | 23D. ADDRESS 6101 Park Heights Ave. Balto Md 21215 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) JOHNS HOPKINS CHURCH | | 24B. DATE 1/30/71 | | 24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MED. SCHOOL | |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD 21205 | | 25A. DATE REC'D BY HEALTH DEPT. FEB 3 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Walter Lewis | | | |
| 25D. ADDRESS 9610 Ruston Rd | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0982 | |
|--|---------|--|------------------|--|----------------------------|
| T-460 71 0982 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | JULIA TYLER | | 1/29/71 8:15 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | |
| 90 Gould Nursing Home | | Md. 21224 | | 6-02 | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 403 N. Glover St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| female | white | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 2/16/86 | 84 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | at home | | Baltimore, Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph Planner | | unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 212-14-4987B | | 703 S. DECKER Decker Ave. | |
| | | | | William A. Hartlove, nephew | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 4 days | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | weeks | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | years | |
| II | | Other Significant Conditions Contributing to the Death but Not Related to the Terminal Disease or Condition Given in Part I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
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| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from | | 11/24/1970 to | | 1/29/1971 | |
| that (I) (the) last saw the deceased alive on | | 11/25/1970 | | and that in (my) (our) opinion death occurred on the date | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| [Signature] | | 1/29/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Buxiat | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/1/71 | | Bohemian Nat. Cem. | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 2 1971 | | Robert E. Taylor, M.D. | | Schmonek Funeral Home, Inc. | |
| | | | | 2601 E. Madison St. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

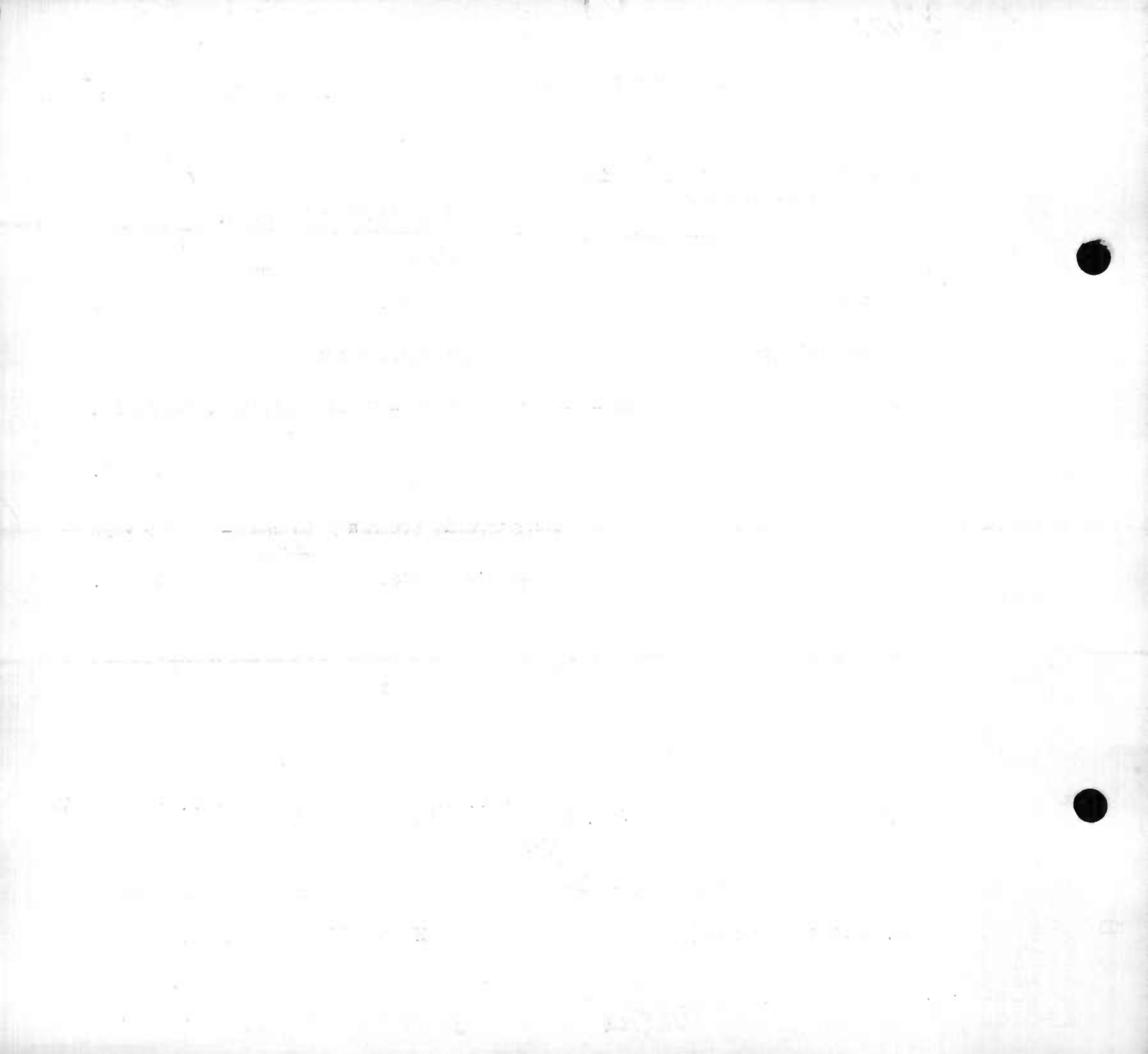
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0983 | |
|--|---------|--|------------------|--|--------------------------------|
| 0-236 71 0983 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 0-236 71 0983 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Margaret | | 2. DATE AND HOUR OF DEATH | | | |
| MARGRET F. OSTER | | JAN 29 At 7 12:25 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| MONTEBELLO STATE Hosp | | MARYLAND | | | |
| 91 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 2619 EDISON HIGHWAY | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. If Under 1 Yr. Months Days |
| F | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 11-09-05 | 64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | at home | | N. Carolina | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Smoot | | unknown | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 1101 Tower Bldg. Eugene Schonfield, Atty. | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | 1969 | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-28 1970 to JAN 29, 1971 that (I) (we) last saw the deceased alive on JAN 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| H. Drayton M.D. DEGREE | | | | 1/29/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| M. INAYATULLAH M.D. DEGREE | | | | MONTEBELLO HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/1/71 | | Loudon Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 2 1971 | | R. B. E. J. B. R. A. 0 0 0 | | Schmuck Funeral Home, Inc. 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

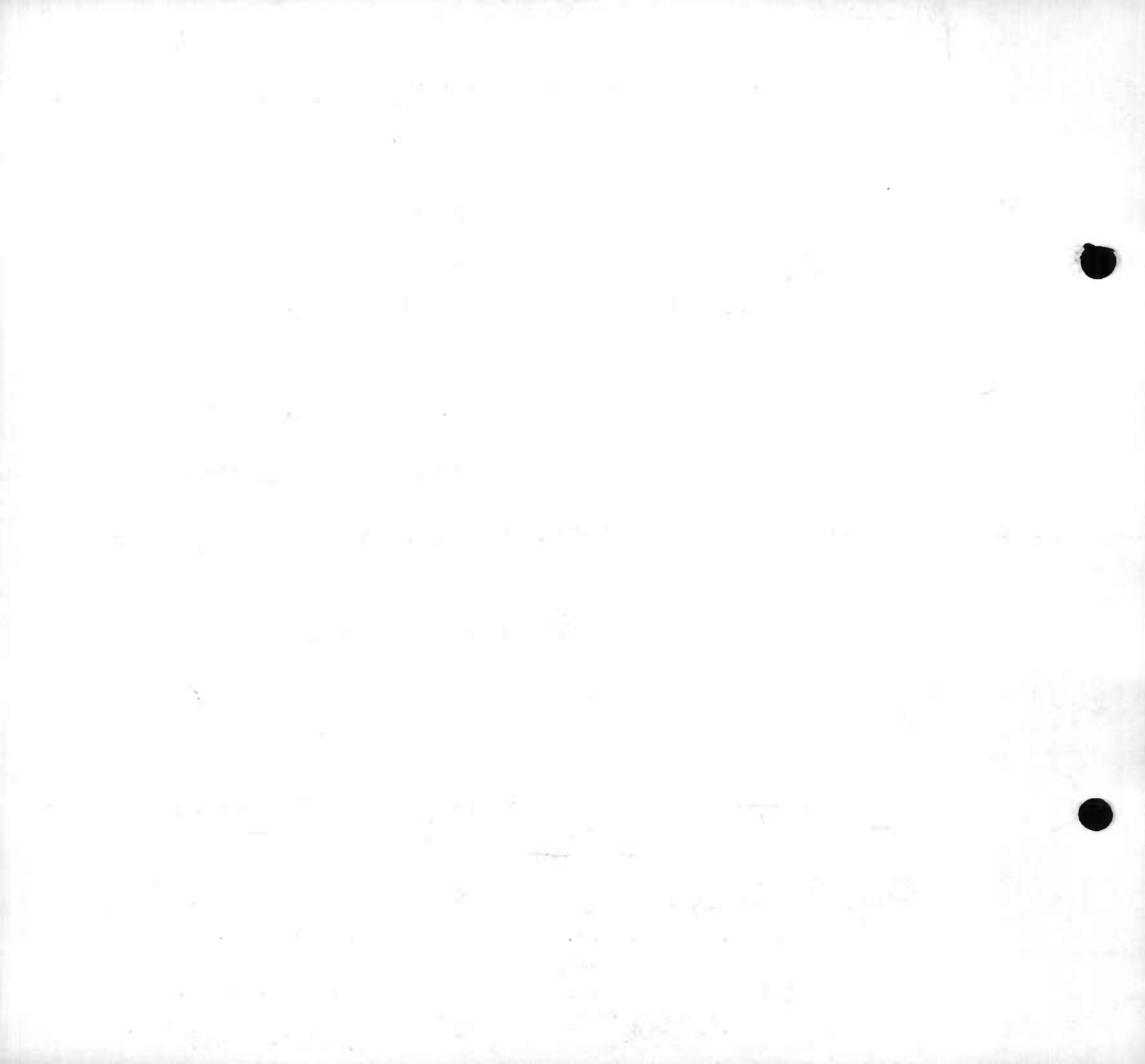
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0984 | |
|--|--|---|--|--|--|
| BIRTH NO. 6-421 | | | | 71 0984 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| Theresa Alverta Gleespen | | | | Jan. 28, 1971 3: 15 PM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway | | | | A. STATE Md. B. COUNTY 26-33 | |
| 5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 8. DATE OF BIRTH 6/9/28 9. AGE (in years last birthday) 42 | | | | E. STREET AND NUMBER 3140 Chesterfield Ave. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Md. Baltimore | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert Galster | | | | 14. MOTHER'S MAIDEN NAME Madeline Arata | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 217-24-0315 | |
| 17. INFORMANT | | | | ADDRESS | |
| Records | | | | US PHS Hospital, Balto, Md. | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic shock 12 hrs. | |
| | | | | (B) Pancytopenia secondary to chemo-therapy 5 days | |
| | | | | (C) Hodgkin's disease 20 mos. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 27 19 71 to Jan. 28 19 71 that (I) (we) last saw the deceased alive on Jan. 28 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William H. Greene M.D. | | | | 23B. DATE SIGNED 1/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) Wm. Greene, Surgeon (R) | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/1/71 | | Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | | |
| Baltimore, Md. | | FEB 2 1971 | | | |
| 25A. NAME OF REGISTRAR | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| Schimunek Funeral Home, Inc. | | 3331 Brehms Lane | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

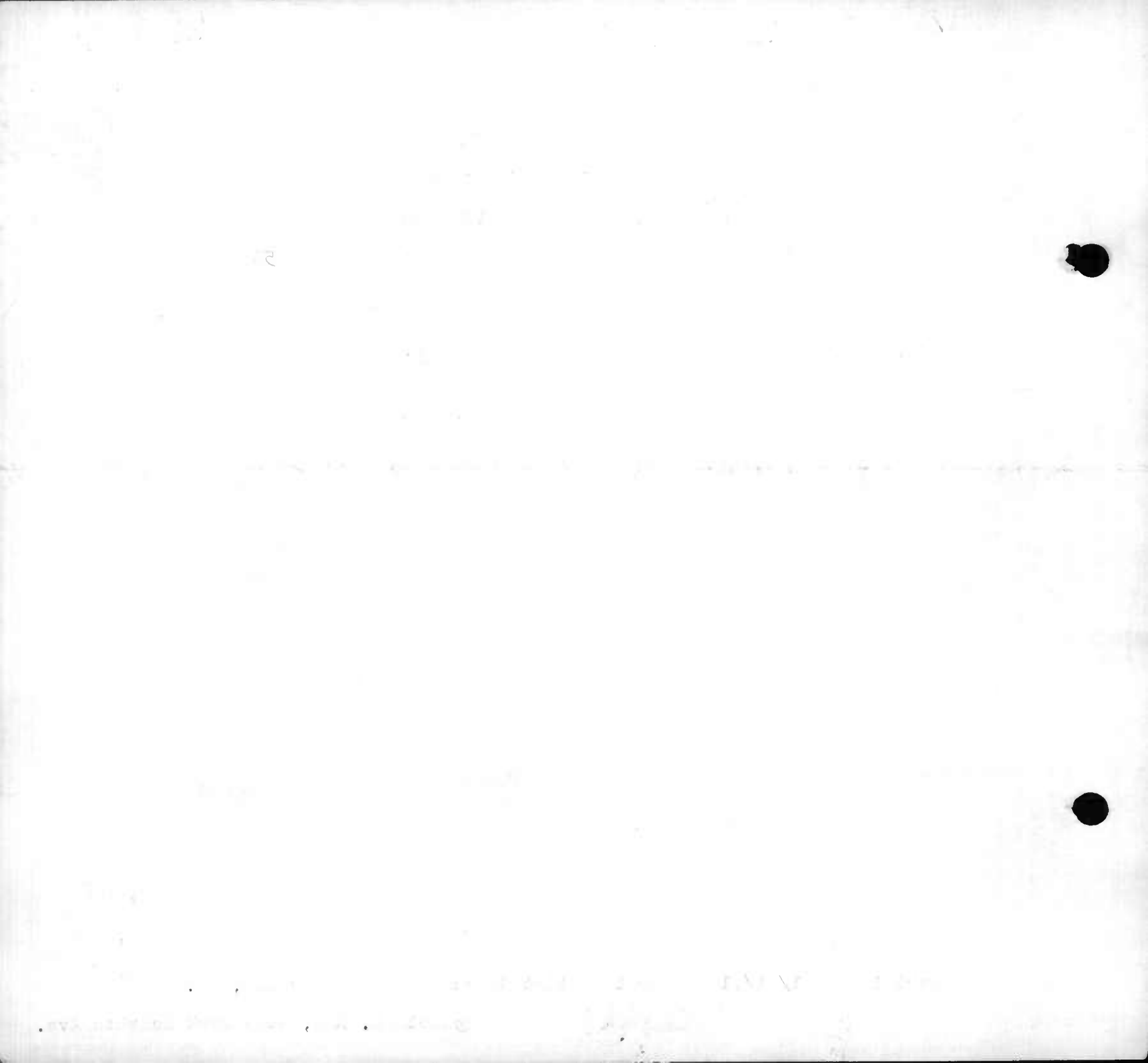
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0985 | |
|---|--|--|--|---|--|
| 71 0985 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Rev. Francis W. Vonasek C, S.S.R. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH Jan. 29, 1971 9:15 a. M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21205 | | | |
| 2111 Ashland Avenue | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX male | | 6. RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8/16/09 | | 9. AGE (In years last birthday) 61 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest | | 10B. KIND OF BUSINESS OR INDUSTRY St. Wenceslaus Church | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Frank Vonasek | | 14. MOTHER'S MAIDEN NAME Anna Kuba | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Anna Novak, sister | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9+1250.9 CORONARY THROMBOSIS SPONTANEOUS | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II ARTERIOSCLEROTIC HEART DISEASE 3 YRS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 21. DIABETES MELLITUS | | 22. 2 YRS | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/18 19 67 to 1/29 19 71 that (I) (we) last saw the deceased alive on 1/29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Henry J. Houska | | 23B. DATE SIGNED 2/1/71 | | 23C. PHYSICIAN'S NAME (Type) Henry R. Houska, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/2/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. ADDRESS 333 S. East Ave. | | 24F. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | |
| 24G. ADDRESS 2601 E. Madison St. | | 24H. NAME OF REGISTRAR E. J. Taylor, Md. | | 24I. ADDRESS 2601 E. Madison St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0986 | |
|--|---|--|---|--|--|
| D-525 71 0986 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Duncan, Mary | | 2. DATE AND HOUR OF DEATH 1/25/71 4:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215 | | A. STATE Maryland B. COUNTY 15-01 | | | |
| | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 1442 Presstman St. | | | |
| 5. SEX Female | 6. RACE Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/01/17 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Pet Abbott | | 14. MOTHER'S MAIDEN NAME Merliza Abbott | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Preston Duncan-Husband | |
| 18. ADDRESS Same | | 19. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary embolus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. | |
| (B) Embolicism Pulmonary, Cereb. + Cardiac | | (C) Hypertension | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/18/71 19__ to 1/25/71 19__ that (I) (we) last saw the deceased alive on 1/25/71 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Webster Sewell M.D. | | | | 23B. DATE SIGNED Jan. 26, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) WEBSTER SEWELL M.D. | | | | 23D. ADDRESS 2600 Liberty Heights Ave. Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 1/31/71 | | 24C. NAME OF CEMETERY OR CREMATORY First Baptist Church | |
| 24D. LOCATION (City, town, or county) (State) Mappsville, Va. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 | | 25B. NAME OF REGISTRAR Robert Taylor | | 25C. FUNERAL DIRECTOR Kenneth H. Law | |
| 25D. ADDRESS 4609 Park Heights Ave. | | | | | |



CERTIFICATE OF DEATH

REG. NO. 71 0987

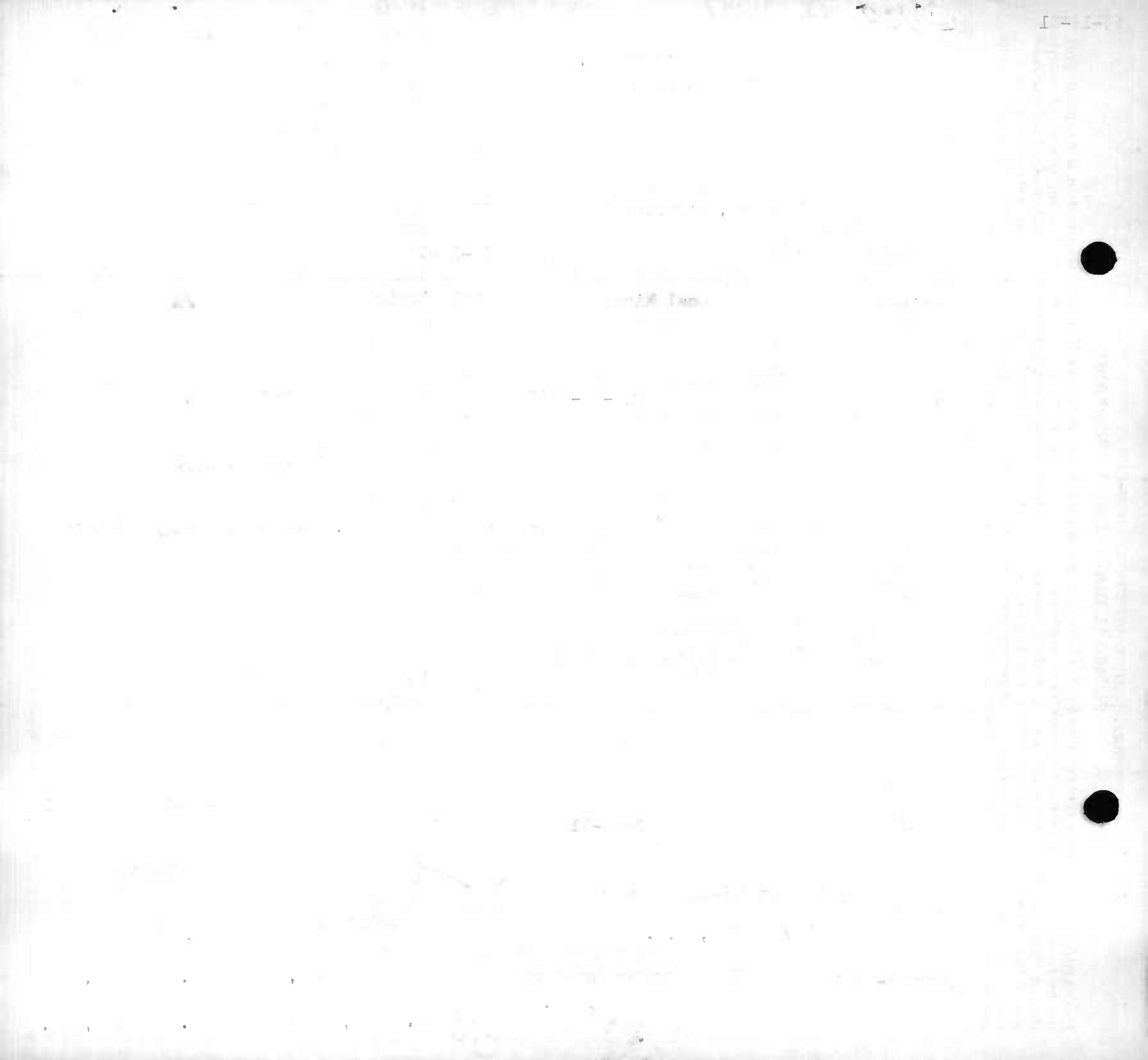
| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Cobb, Samuel</i> | | 2. DATE AND HOUR OF DEATH <i>1/29/71</i> <i>DoA</i> <i>2:22</i> <i>A.</i> <i>M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>3/1/99</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>Dundalk</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <i>Male</i> | | 6. RACE <i>white</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Coal Miner</i> | | 8. DATE OF BIRTH <i>10-12-78</i> | |
| 13. FATHER'S NAME <i>?</i> | | 14. MOTHER'S MAIDEN NAME <i>?</i> | | 9. AGE (In years last birthday) <i>92</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i> | | 16. SOCIAL SECURITY NO. <i>234-14-1118</i> | | 17. INFORMANT <i>BCH RECORDS</i> | |
| 18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Probable Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Ascend</i> (B) <i>CoPD / Granulomatous disease lung 30 y/o</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>1-29-71</i> to <i>1-29-71</i> that <i>(X)</i> (we) last saw the deceased alive on <i>1-29-71</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the cause(s) stated above. <i>(X)</i> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>D. Juan</i> David Juan, M.D. | | | | 23B. DATE SIGNED <i>1/29/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue, 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal-Burial</i> | | 24B. DATE <i>2/1/71</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Barker Cemetery</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talley</i> | | 25C. FUNERAL DIRECTOR <i>John J. Duda</i> | |
| | | | | ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED TO HOSPITAL NON-MED

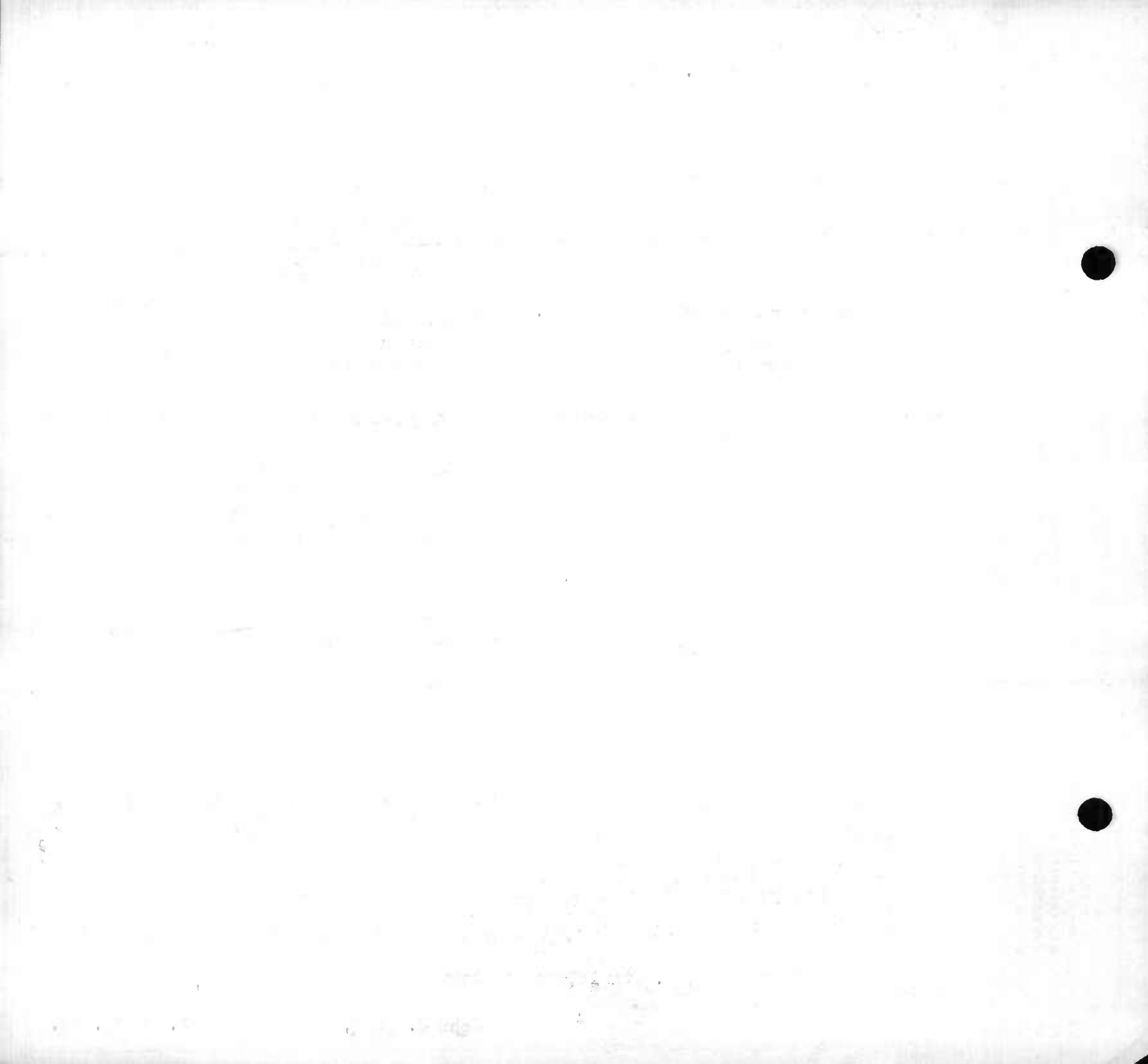
D.O.A.



FUNERAL DIRECTOR: IMPORTANT

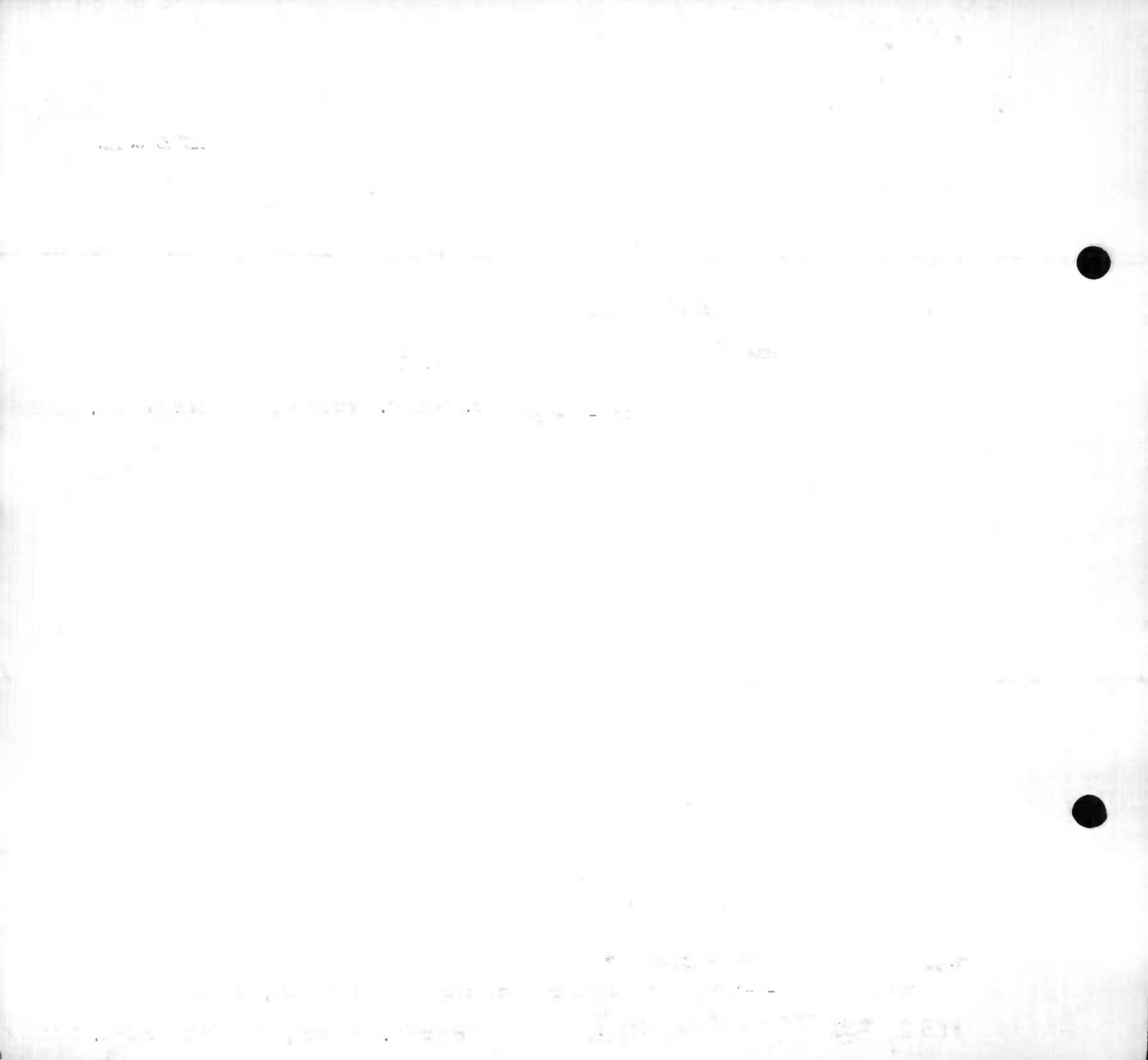
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. <u>71 0988</u> | |
|--|----------------------|---|---|---|---|
| BIRTH NO. <u>K-640</u> | | 71 0988 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Thomas J. Krul</u> | | | 2. DATE AND HOUR OF DEATH <u>1-28-71</u> <u>2:30 P. M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home & Hospital</u> <u>Church Home and Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1-02</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>15 S. Robinson St</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-24-90</u> | 9. AGE (in years last birthday) <u>80 yrs.</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - American Refining Co.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | |
| 13. FATHER'S NAME <u>Not Known</u> | | | 14. MOTHER'S MAIDEN NAME <u>Not Known</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-10-2101</u> | | 17. INFORMANT <u>Cook, Elizabeth (daughter)</u> ADDRESS <u>155 Robinson</u> | |
| 18. <u>413.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>1/28/71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular Accident</u> <u>Massive Left Sided Thrombosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Severed Spinal Cord</u> (C) <u>Intermittent Cardiac Disease</u> <u>Cardiovascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several Days</u> <u>Years</u> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20</u> 19 <u>71</u> to <u>Jan. 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Jan. 28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Rolando Mendoza</u> | | | 23B. DATE SIGNED <u>1/28/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ROLANDO MENDOZA, MD.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>2/2/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1971</u> | | |
| 25B. NAME OF REGISTRAR <u>John V. Duda</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>2829 Hudson St. Balto. Md.</u> | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

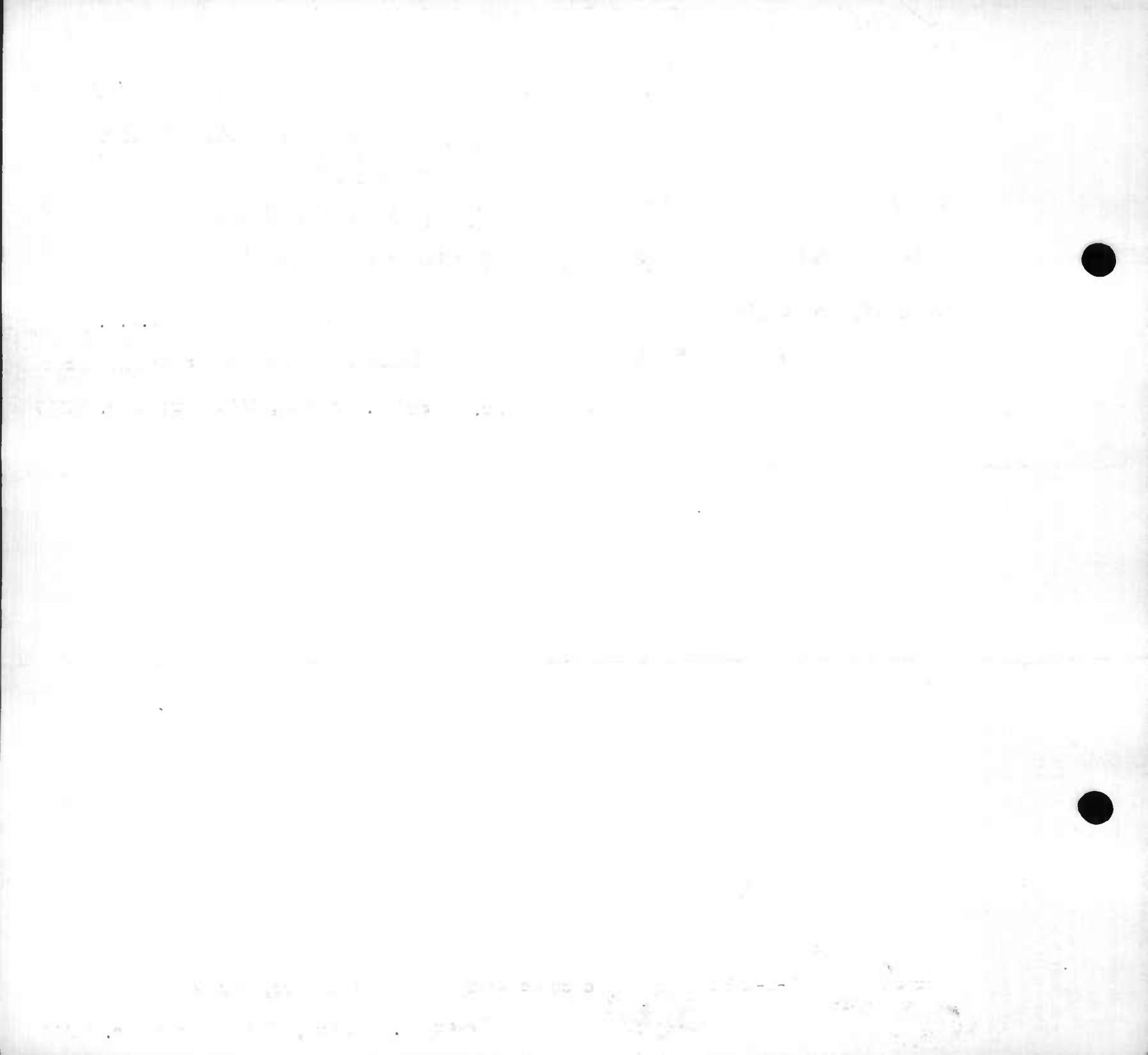
| | | | | | |
|--|-----------------------------|---|---|--|---|
| 11-625 71 0989 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0989 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Marciano, Mrs. Helen T.</i> | | | 2. DATE AND HOUR OF DEATH <i>1/29/71</i> <i>11 05 A.M.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> <i>34</i> | | | A. STATE <i>MARYLAND</i> B. COUNTY <i>25-41</i> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <i>BALTIMORE</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <i>4524 Parkton St.</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9/24/26</i> | 9. AGE (In years last birthday) <i>44</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Avalon Hill</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Philip Kirwan</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mabel</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>220-18-9925</i> | 17. INFORMANT ADDRESS <i>Mr. Carl G. Marciano, 4524 Parkton St. 21229</i> | | |
| 18. <i>41091</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Myocardial infarction</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary atherosclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>?</i> | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>January 25</i> 19 <i>71</i> to <i>January 29</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>January 29</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Chumhak Pruk Sapong M.D.</i> | | | | 23B. DATE SIGNED <i>January 29, 1971</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>CHUMSAK PRUK SAPONG M.D.</i> | | | | 23D. ADDRESS <i>Bon Secours Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-2-1971</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Kelley</i> | | 25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i> | |
| | | | | ADDRESS <i>4107 Wilkens Ave. 21229</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

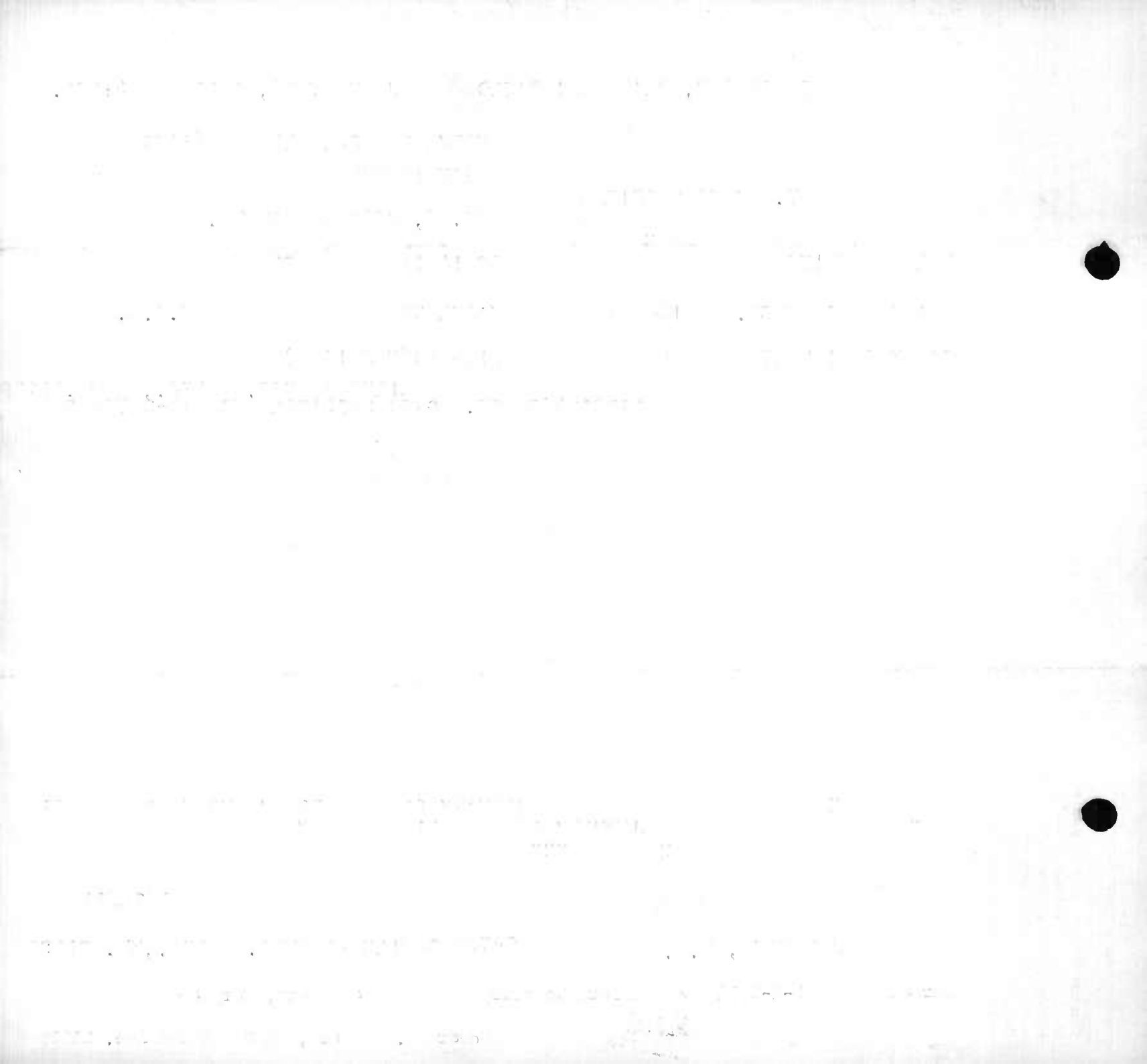
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0990 | |
|--|---|---|---|---|---|
| BIRTH NO. 8-534 | | 1. NAME OF DECEASED (Type or Print) Mrs. Mary G. Kendall | | 2. DATE AND HOUR OF DEATH 1-28-71 1:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Batto. (XXXXXX) | | |
| | | | C. CITY OR TOWN ARBUTUS | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER 1221 North Avenue | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-16-00 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXX Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Jacob P. Luers | | |
| 14. MOTHER'S MAIDEN NAME XXXXXXXXXX Elizabeth Buckheit | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. C | | | 17. INFORMANT ADDRESS Mr. Edward M. Kendall, 1221 North Ave. 21227 | | |
| 18. 431.9 I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE CVA - DUE TO, OR AS A CONSEQUENCE OF: possible intracerebral hemorrhage. | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 27 19 71 to Jan. 28 19 71 that (I) (we) last saw the deceased alive on Jan. 28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Helen Ann Sabundano | | | | 23B. DATE SIGNED 1-28-71 | |
| 23C. PHYSICIAN'S NAME (Type) ROLEND M. SABUNDANO | | | | 23D. ADDRESS Bon Secours Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 | | | |
| 25B. NAME OF REGISTRAR John E. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. | | 71 0991 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. | | 71 0991 | |
|--|--|---------|--|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | | | FARINHOLT, OLIVER WINFIELD | | | | 2. DATE AND HOUR OF DEATH JANUARY 28, 1971 4:15A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | MARYLAND CARROLL 21157-5600 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | ST. AGNES HOSPITAL | | | | C. CITY OR TOWN WESTMINSTER | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER RT. 6, BEAR BRANCH RD. | | | | 5. SEX MALE | | | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 10 14 18 | | | | 9. AGE (in years last birthday) 52 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE ENGR. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FRANK FARINHOLT | | | | 14. MOTHER'S MAIDEN NAME MILDRED (HARRISON) | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 217012485 | | | | 17. INFORMANT WILKENS AVES. BALTO. MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON & | | | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 19A. DATE OF OPERATION 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hosp(ital)) attended the deceased from JANUARY 22 19 71 to JANUARY 28 19 71 that (X) (we) last saw the deceased alive on JANUARY 28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. 23A. SIGNATURE E MOHLER, M.D. 23B. DATE SIGNED 01/28/71 23C. PHYSICIAN'S NAME (Type) E MOHLER, M.D. 23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2-1-1971 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 25B. NAME OF REGISTRAR Howard H. Hubbard 25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 0992 | |
|--|-----------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| CARRIE E. DALRYMPLE | | 1/29/71 18:24 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 SAINT AGNES Hospital Caton + Wilkens Ave | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 4307 BARRINGTON Rd | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/18/89 | 9. AGE (In years last birthday) 81 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Henry Broseker | | | 14. MOTHER'S MAIDEN NAME Louisa F. Hoffman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 21229 Mr. Edwin W. Dalrymple, 4307 Barrington Rd. |
| 18. 457.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EMBOLISM ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 1990 to Jan 29 19 71 that (I) (we) last saw the deceased alive on Jan 29 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Earl Pass | | | 23B. DATE SIGNED 1/29/71 | | |
| 23C. PHYSICIAN'S NAME (Type) Earl Pass | | | 23D. ADDRESS 4001 Wilkens Avenue, Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |

more, Maryland

Maryland,

b.

J-162

71 0993

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 0993

BIRTH NO.

| | | | | | | | |
|--|-------------------------|--|--|--|------|---|------|
| 1. NAME OF DECEASED (Type or Print) Witmer M. Jefferson | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month | | Day | Year | Hour | M. |
| | | 1 | | 28 | 1971 | 8:25 p | M. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland | | B. COUNTY Baltimore | | | | | |
| 6. SEX male | 7. RACE white | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Woodlawn | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH 12/24/03 | | 10. AGE (In years lost birthday) 67 | | E. STREET AND NUMBER 2010 Woodlawn Drive | | 21207 | |
| 11. BIRTHPLACE (State or foreign country) Fredericksburg, Virginia | | 12. CITIZEN OF U. S. A. | | 13. FATHER'S NAME Robert L. Jefferson | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee | | 14B. KIND OF BUSINESS OR INDUSTRY Beatrix Radio Corp | | 15. MOTHER'S MAIDEN NAME Alice Dye | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 212-05-8272 | | 18. INFORMANT Mrs. Mae K. Jefferson, 2010-G Woodlawn Drive 21207 | | | |
| 19. 412.214250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive & arteriosclerotic cardiovascular disease | | CAUSE OF DEATH Hypertensive & arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Diabetes mellitus | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. | | | | | | | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 1-29-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT. FEB 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Loring Byers Funeral Directors P.A. | | ADDRESS 8728 Liberty Road, Randallstown, Md. 21133 | |

VS 151-REV. 7/7/68

N 994.8

1909

INDIAN EXAMINER & CERTIFICATE OF DEATH

1909

1909

1909

1909

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-632 71 0995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 0995

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Ortgies, Howard S.

2. DATE AND HOUR OF DEATH

1-27-71

10:30

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

301 Oakdale Road

21290*

21090

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-24-01

9. AGE (In years
last birthday)

69

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sales Manager

10B. KIND OF BUSINESS OR INDUSTRY

Import-Export

11. BIRTHPLACE (State or foreign country)

New York, N.Y.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William S. Ortgies

14. MOTHER'S MAIDEN NAME

Sarah Jefferies

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW2

Navy

16. SOCIAL
SECURITY NO.

089-03-2319

17. INFORMANT

BCH RECORDS

ADDRESS

4940 Eastern Avenue

Baltimore, Md. 21224

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) ACUTE LEUKEMIA

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 hr

10 mo.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSE OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~XX~~ (this hospital) attended the deceased from 1/27 19 71 to 1/27 19 71
that (I) ~~XX~~ last saw the deceased alive on 1/27 19 71 and that in (my) ~~XX~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~XX~~ (did) (did not) view the body after death.

23A. SIGNATURE

John Neefe

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/27/71

23C. PHYSICIAN'S
NAME (Type)

John Neefe, M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/30/71

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Balto. Md. 21229

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

McGulley Funeral Home Balto. Md. 21225

1. The first of the three main points of the report is that the Army is in a position to meet the requirements of the War Department.

2. The second point is that the Army is in a position to meet the requirements of the War Department.

3. The third point is that the Army is in a position to meet the requirements of the War Department.

4. The fourth point is that the Army is in a position to meet the requirements of the War Department.

5. The fifth point is that the Army is in a position to meet the requirements of the War Department.

6. The sixth point is that the Army is in a position to meet the requirements of the War Department.

7. The seventh point is that the Army is in a position to meet the requirements of the War Department.

8. The eighth point is that the Army is in a position to meet the requirements of the War Department.

9. The ninth point is that the Army is in a position to meet the requirements of the War Department.

10. The tenth point is that the Army is in a position to meet the requirements of the War Department.

11. The eleventh point is that the Army is in a position to meet the requirements of the War Department.

12. The twelfth point is that the Army is in a position to meet the requirements of the War Department.

71 0996

CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JENNIE HENKIN

2. DATE AND HOUR OF DEATH

JAN 28, 1971 7:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

6703 Gary Avenue 21224

5. SEX

Female

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

JUNE 11 1904

9. AGE (In years last birthday)

67 66

10. Under 1 Yr.

Months: Days: Hours: Min.

11. Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Segelski

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: Records Baltimore, Maryland 21224

18. 250.91 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARRHYTHMIA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(C)

Diabetes mellitus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

~ minutes

~ 20 years

~ 20 years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

(APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-8-71 to 1-19-71 that (I) (we) last saw the deceased alive on 1-27-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Richard K. Maza MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-28-71

23C. PHYSICIAN'S NAME (Type)

RICHARD K. MAZA MD

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-2-71

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

Baltimore Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1971

25B. NAME OF REGISTRAR

John E. ...

25C. FUNERAL DIRECTOR

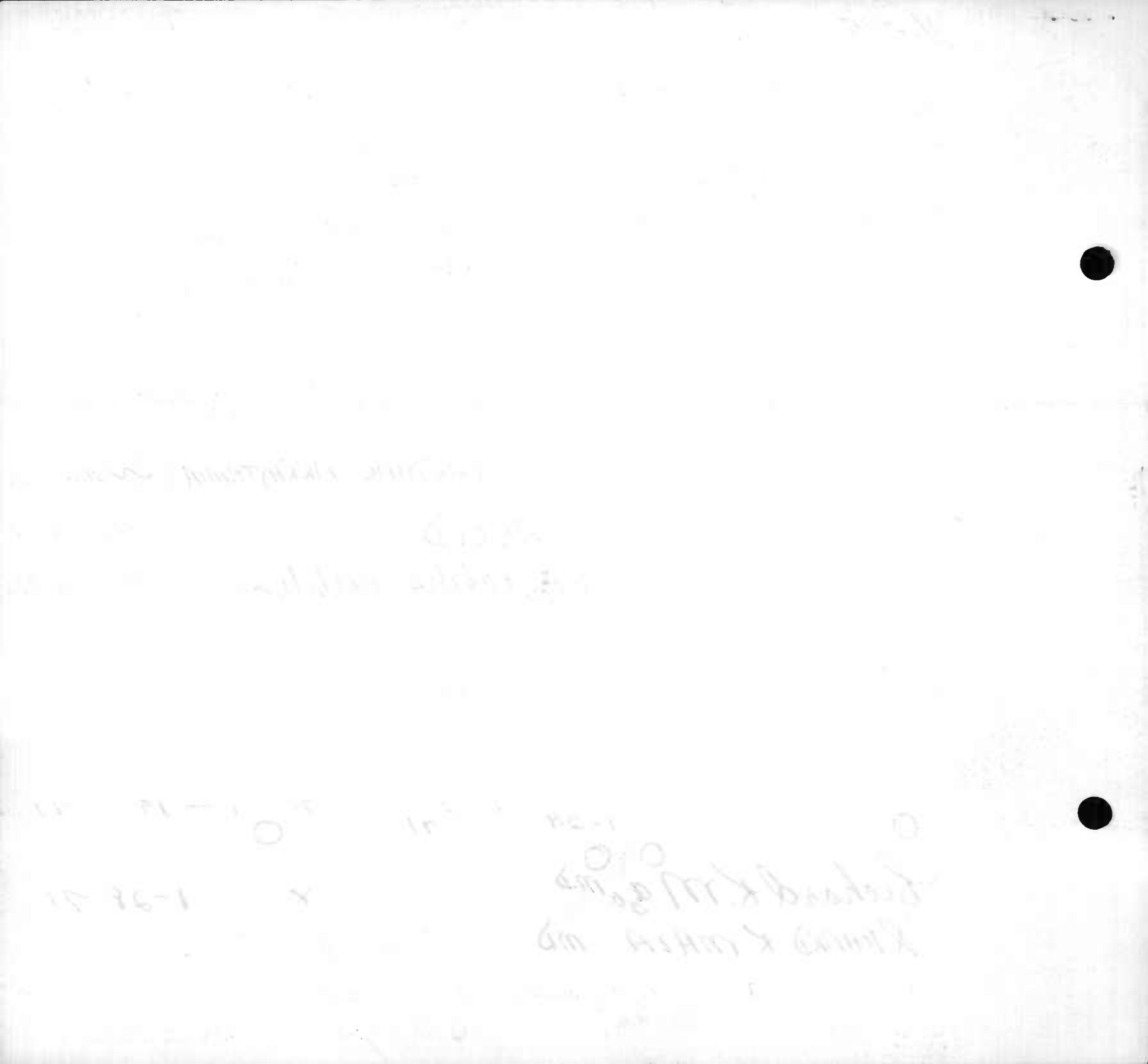
WALTER DABROWSKI 1005 DUNDALK AVENUE

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

DOA RELEASED BY MEDICAL EXAMINER NON-MED



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 0997 | | 71 0997 | |
|--|---------------------|---|--|--|--|---|--|
| BIRTH NO. | | | | REG. NO. | | 71 0997 | |
| 1. NAME OF DECEASED (Type or Print) Bettie Osborne | | | | 2. DATE AND HOUR OF DEATH 1/30/71 12:20 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto. Md. B. COUNTY BALTO, Co. 5300 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Balto. Co | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER Rt. #1 Box 539 Balto. Md. | | | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 02/08/93 | | 9. AGE (in years last birthday) 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homekeeping | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Marshall Roupe | | | | 14. MOTHER'S MAIDEN NAME Matilda Roupe Sturgill | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-26-7573 | | 17. INFORMANT Mrs. Violet M. Beck ADDRESS Rt. 1 Box 539 Balto. Md. 21221 | | | |
| 18. CAUSE OF DEATH 200-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) widespread lymphosarcoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). widespread carcinomatosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 12-30-70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory laparotomy | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-21 19 70 to 1-30 19 71 that (I) (we) lost saw the deceased alive on January 30 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H. E. Bondy, M.D. | | | | 23B. DATE SIGNED January 30, 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) H. E. Bondy | | 23D. ADDRESS 301 S. P. 1 Street Baltimore Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-1-1971 | | 24C. NAME of CEMETERY or CREMATORY Belair Memorial Gardens | | 24D. LOCATION (City, town, or county) (State) Bel Air Harford Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, R.A. | | 25C. FUNERAL DIRECTOR Lassahn Funeral Home | | ADDRESS 7401 Belair Rd. 21236 Baltimore, Md. | |

FUNERAL DIRECTOR: IMPORTANT

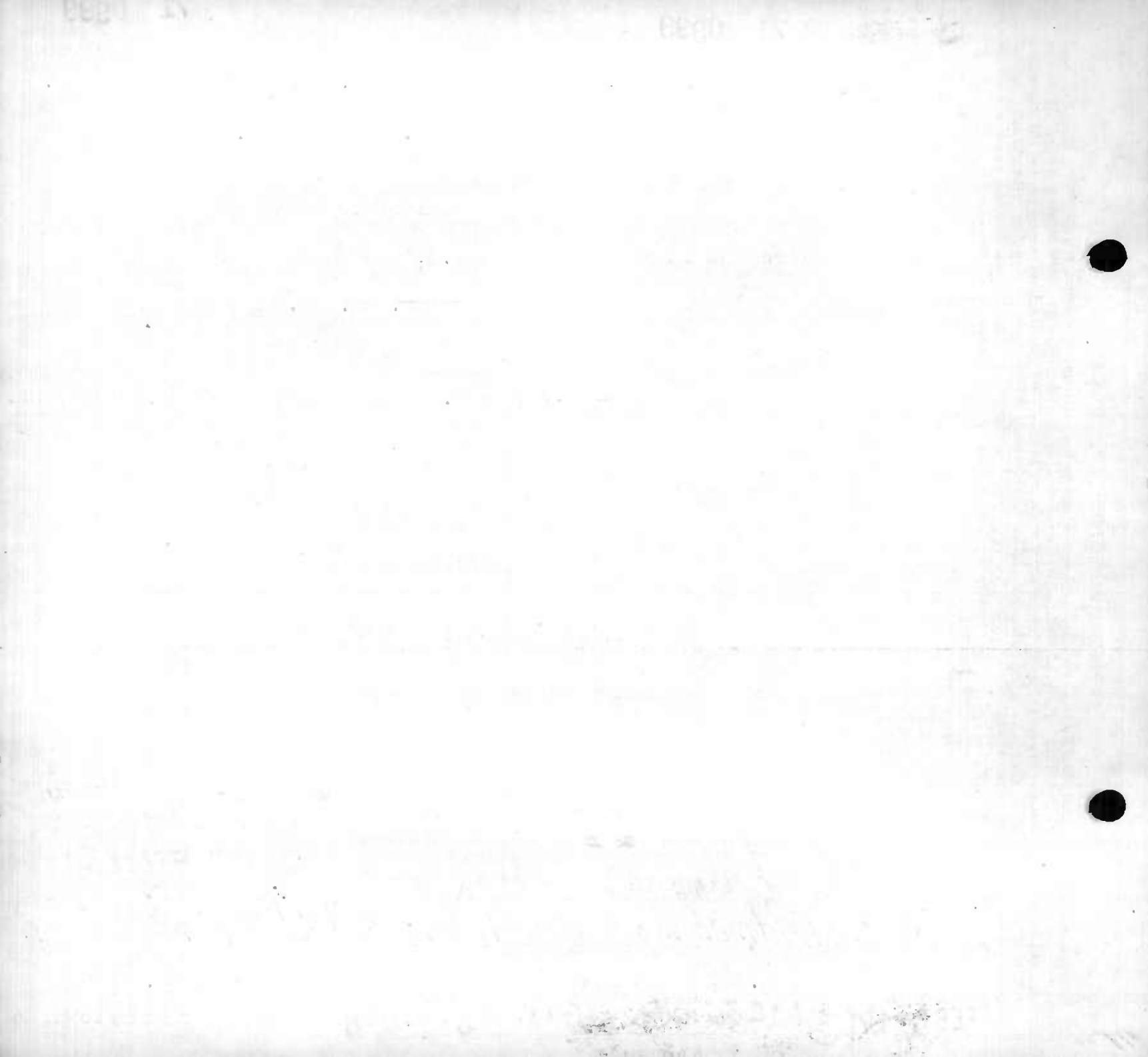
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 0998 | |
|--|---------------------|---|--|---|--|
| M-600 71 0998 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) John Moore, F | | 2. DATE AND HOUR OF DEATH 1/28/71 4:10 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 12-06 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 2106 St Paul St | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-8-72 | 9. AGE in years (last birthday) 98 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursery Worker | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? American | | | | | |
| 13. FATHER'S NAME John F. Moore | | 14. MOTHER'S MAIDEN NAME Anna Oakley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 216-24-7438 | | 17. INFORMANT Chart | |
| 18. 485X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Bilateral Bronchopneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) ----- | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/26 19 71 to 1/28 19 71 | | | | | |
| that (I) (we) last saw the deceased alive on 1/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE I. Cheik | | 23B. DATE SIGNED 1/28/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) ISSAM E. CHEIKH | | 23D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/1/71 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Ritchie Hwy. A.A. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Taber, Jr. | | 25C. FUNERAL DIRECTOR McGully Funeral Home | |
| 25D. ADDRESS 237 Patuxent Ave. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------------|--|-----------------------------------|--|--|
| J-635-71 0999 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 0999 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | Louise T. Jordan | | 2. DATE AND HOUR OF DEATH Jan. 28, 1971 9:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. 53-00 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1333 Stockton Street | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Reisterstown, | | | |
| | | D. STREET ADDRESS (If rural, give location) Caltrider Lane | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Sept. 8, 1904 | 9. AGE (In years lost birthday) 66 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Co. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Charles Turner | | 14. MOTHER'S MAIDEN NAME Mary Randall | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-07-9847 | | 17. INFORMANT Mrs. Marion Johnson | |
| | | | | ADDRESS Reisterstown, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 I | | CAUSE OF DEATH (A) Polmonary & Brain Embolism DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Myocardial Infarct DUE TO | | 12 hrs | |
| | | (C) Possible Cardiac Arrest | | 1 hr | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Fibrillation, ASCVD. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-2-1967 to 1-28-1971, that (I) (we) last saw the deceased alive on 1-28-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Marlin J. Feldmann | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1/29/71 | |
| 23C. PHYSICIAN'S NAME (Type) Martin J. Feldman M.D. | | 23D. ADDRESS 1 Cherry Hill Rd Reisterstown Md 21367 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Jan. 30, 71 | | 24C. NAME of CEMETERY or CREMATORY St Lukes Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Reisterstown, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 1971 | | 25B. NAME OF REGISTRAR John E. Fisher, Jr. | | 25C. FUNERAL DIRECTOR J. F. Elme & Sons | |
| | | | | ADDRESS Reisterstown, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|------------------------------------|---|--|
| G-256 71 1000 | | CERTIFICATE OF DEATH | | REG. NO. 71 1000 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) GEGNER, JOHN, A. | | 2. DATE AND HOUR OF DEATH 1/29/71 2:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE | | 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION BAC.H. BALTIMORE CITY HOSPITALS | | C. CITY OR TOWN EAST POINT | | D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 7406 Belmont Avenue #21224. | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2-26-95 | 9. AGE (In years last birthday) 75 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY CARPENTER | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME Charles Henry GEGNER | | 14. MOTHER'S MAIDEN NAME Caroline Rehmert | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-01-9918 | | 17. INFORMANT HELEN N. WILLIS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Gram negative sepsis | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) Acute hemorrhagic pancreatitis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Atrial Fibrillation, PNEUMONIA | | | |
| 19A. DATE OF OPERATION 1/19/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Pancreatitis | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 1-17-71 to 1-29 19 71 that (X) (we) last saw the deceased alive on January 29 19 71 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE John M. Kellum, Jr. M.D. | | 23B. DATE SIGNED 1/29/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) John M. Kellum, Jr. M.D. | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-1-71 | | 24C. NAME of CEMETERY or CREMATORY OAK LAWN CEM. | |
| 24D. LOCATION 7225 EASTERN BLVD. BA. CO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 2 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR 6224 EASTERN AVE. BALTO., 21224, MD. | |

